On Terminal Disinfection

By Col. R. St. J. MACDONALD, M.D., D.P.H., Montreal

There is going on at the present time in medical journals, on both sides of the Atlantic, a fairly widespread discussion regarding the necessity of terminal disinfection. In the minds of many general practitioners and some medical officers of health, there is a good deal of doubt as to the disinfection necessary in the routine treatment of the common communicable diseases. This is not surprising, when there exists well defined differences of opinion amongst the world's leading sanitarians.

Not many years ago he was a bold individual who questioned the need of terminal disinfection or even terminal fumigation. Today there are those who are seriously sceptical of the practical value of isolation and quarantine.

The importance of disinfection was deeply implanted in medical men during the second era in the development of modern public health, when the discoveries of Pasteur and the application of bacteriology gave a new turn to preventive medicine. For twenty-five years the best efforts of public health workers were directed to securing efficient isolation, quarantine and disinfection when dealing with communicable diseases, and all credit must be given that generation for its accomplishments. But notwithstanding their enthusiasm and faith their success was limited and these diseases continued their course as before.

Why? Because the advances made in the knowledge of bacteria and epidemiology, and the development of laboratory methods showed these diseases were not and could not be completely stamped out by these means alone. This for the reason that many are communicable before the disease is recognized; because mild and atypical cases are missed, and on account of the menace of the carrier.

With this newer knowledge there came, too, the belief that certain communicable diseases are spread directly from sick to well by contact and droplet infection—that the person and not the place is dangerous. Such being the case, it naturally followed that doubts should arise as to the necessity for terminal disinfection. In order to make things clear it would be well at this stage to give some definitions.

Communicable diseases are those caused by specific micro-organisms. The terms contagious and infectious are no longer used as they are misleading and confusing. Under the term communicable diseases are included the following: Measles, German measles, scarlet fever, whooping cough, diphtheria, smallpox, chickenpox, mumps, cerebrospinal meningitis (epidemic), actinomycosis, ankylostomiasis, dengue, poliomyelitis, septic sore throat, syphilis, trachoma, acute infectious conjunctivitis, tuberculosis, anthrax, cholera, favus, glanders, leprosy, paratyphoid fever, pneumonia (acute lobar), rabies, dysentery, gonorrhoea, malaria, plague, Rocky Mountain fever, tetanus, trichinosis, typhoid fever, typhus fever, yellow fever.

It is understood that the modes of transmission of these diseases are:

1. Direct: (a) direct contact (b) indirect contact.
2. Indirect: water, food, soil, etc.
3. Intermediate hosts: flies, fleas, mosquitoes, etc.

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Direct contact occurs when the infection is carried to the mouth or nose, as in kissing, or close association, or in droplet infection when the germs are coughed or sneezed into the faces of others.

The indirect contact transmission of diseases may occur if articles or objects, wet with secretions, such as towels, toys, pencils, eating utensils, linen, etc., are carried to the mouths of susceptible individuals, or if fingers touching such are brought to the mouth or nose. Contact infection implies a rapid and close transfer of infectious material from person to person.

Disinfection means the destruction of pathogenic bacteria.

Concurrent disinfection is that carried on during the course of the illness, and implies the quick disinfection of all discharges and secretions and articles freshly soiled with such secretions.

Terminal disinfection is performed after the recovery, removal or death of the patient, and is applied to the room and its contents. Fumigation implies the destruction of bacteria, mosquitoes and small animals by means of gases.

In the early days of the germ theory the air was supposed to have been the chief medium for the transmission of disease germs. It was thought the breath of the patient filled the room and house with infective germs—that the poison was carried outside, even long distances in the air. One writer with a lively imagination said, "Disease is literally borne on the wings of the wind."

The great surgeon, Lister, believed in the air-borne theory, and for some time used a spray of carbolic acid in the immediate vicinity of an operation. The modern surgeon pays no attention to the air of his clean well-ventilated room. In 1881 the Local Government Board in England advised that a smallpox hospital be erected if possible a mile or more from houses.

We know now that diseases are not air-borne; that while the plasmodium causing malaria passes through the air, it is in the body of the mosquito, and if the mosquitoes are removed and kept away from the patient, there is no danger of disease transmission, and we know aseptic nursing prevents the spread of disease in communicable disease hospitals. A typhus patient, after a bath and a clothes' disinfection, may with perfect safety be placed in the general ward of a hospital.

Today, no one ever thinks of putting carbolic acid in open pans for disinfecting the air of rooms, or hanging sheets soaked in corrosive sublimate over doorways.

Germs are present in the moisture of the mucous membranes of the nose and throat, and in the saliva of persons ill with measles, diphtheria, scarlet fever, etc. In coughing or sneezing or loud talking or expectorating this moisture is expelled as a fine mist or minute droplets. The germs rapidly fall to the floor, but they may be suspended long enough in the air to infect others close by, or they may be carried short distances by currents of air. How far they are conveyed is hard to say. Gordon, in ventilating studies in the House of Commons, recovered B. prodigiosus seventy-one feet from an individual who was broadcasting the germs by speaking. Chapin, on the other hand, states animal experiment has shown droplet infection is not effective at a distance greater than two or three feet. Leonard Hill refers to the reduction in the meningococcus carrier rate from 30 per cent. to 2 per cent. when soldiers in sleeping huts were separated by putting the beds two and a half feet apart instead of six inches.

Germs, especially the spray-borne ones, die very soon after leaving the human body. They cannot live long without the warmth and moisture of the body. They die quickly on the dry floors, walls and bed clothes.

Dryness and sunlight are very effective natural disinfectants, and of the two the former is of more practical value. The effect of dryness on the life of bacteria is seen in laboratory practice where many bacteria soon die on dry, artificial media. In fact, it is practically true that non-spore-bearing bacteria die almost as soon as they dry.

Direct sunlight will kill most germs, including the tubercle bacillus, in a few hours. It was formerly thought that the virus of smallpox and the tubercle bacillus were much more resistant than other pathogenic bacteria. But now we know the former dies before the average non-spore-bearing bacteria and the latter is soon killed by direct exposure to the sunlight and air. Rosenau believes it unlikely that dust, under ordinary circumstances, would contain dangerous numbers of live tubercle bacilli. The view generally held is that the danger from spray infection is not great beyond a distance of four or five feet on account of the enormous dilution.

There is, then, every reason to think that such germs do not get very far from the immediate environment of the patient, the bed and contents, in which case the whole room would not be infective.

It may therefore be assumed that the non-spore-bearing bacteria, causing communicable diseases, die very quickly when deposited on dry floors, walls or bed clothes. Those that have not succumbed are very much attenuated.

Again, it is generally believed that the greatest period of infectiveness of such communicable diseases as measles, smallpox, scarlet fever, whooping cough, is before the characteristic symptoms appear and the disease is recognized. So that before convalescence is over, most germs that would have reached walls, floors or clothes, are dead, and the room with its contents by this time is quite free from infection. If the patient is removed to hospital, to another room, or dies during the early acute stage of the illness, there would be more danger of room infection, and need for more extensive disinfection.

It would then seem that in the treatment of communicable diseases, proper concurrent disinfection together with airing and sunning for twenty-four hours would be sufficient to destroy infection.

In the past, too much attention was put on the room and surroundings and too little upon the patient, the actual source of infection. Terminal disinfection after the communicable diseases is not necessary. There is no need for spending time, energy and money in this way, provided efficient concurrent disinfection has been done.

Terminal disinfection has not been practised for years by Dr. C. V. Chapin, Superintendent of Health, Providence, one of the foremost public health administrators in the United States, and no ill results have followed. It has been safely discontinued on a large scale by Professor Chagas, Director-General of Public Health in Brazil. It has been dropped by Dr. W. Rimpau, Director of the Bacterial Institute of Munich. The younger school of sanitarians in England is becoming very sceptical of the value of terminal disinfection after scarlet fever and diphtheria. A committee of the American Public Health Association in a report, in 1923, on the control of communicable diseases, recommended thorough cleansing and airing as the only terminal disinfection necessary in measles, whooping cough, scarlet fever, diphtheria, etc.

It is only fair to state that there are some public health authorities in this country and more in England who still firmly believe in the value of terminal disinfection and fumigation. It is worth noting, however, that the stoutest champion of this school, Professor Kenwood, is on

the defensive and in a recent article in the "Lancet" states that "a prolonged enquiry is necessary to get at the truth, which is elusive and difficult to arrive at, and that in the meantime we are not justified in denying to the public a measure of probable protection."

All the authorities quoted, while favouring, wholly or in part, the dropping of terminal disinfection, yet have an undiminished faith in disinfection itself, when done in the right place and at the right time.

From our present knowledge of bacteriology, and the way in which infection is spread, it would seem that in the control of communicable diseases, greater dividends can be obtained by investing the money now spent on terminal disinfection in:

1. Popular education in personal hygiene by public health nurses, etc.

2. Immunization.

3. Concurrent disinfection.

4. Controlling carriers; missed or atypical cases.

Terminal disinfection as performed at present in many places is useless, and might as well be abandoned. It is not believed in by many medical officers of health, who carry out some form of it because health regulations require that they do so. The value of it is doubted by others who, as a consequence, naturally allow it to be done in a very casual manner. This does not mean, of course, that it is not efficiently completed by many conscientious health officers, whether or not they approve of it.

Conclusion—From this review it would appear our aim should be efficient, concurrent disinfection. Fumigation would only be necessary to destroy mosquitoes, fleas, vermin, etc., when dealing with insect-borne diseases.

Room disinfection — In order to complete this article a short note is added indicating a simple, effective and practical method of carrying out a sick room disinfection.

Disease germs come away in the discharges and secretions of the body. The principal objects therefore requiring disinfection are: sputum, faeces, urine, articles soiled with secretions, and things handled and mouthed by the patient.

There are two extremely important things to be realized in practical disinfection: first, that the disinfectant be efficient; second, that a sufficient quantity be added in the proper strength and that time be given it to reach the imbedded germs.

Sputum—1. Burn all rags, cloths, paper, etc., containing sputum or other discharges from mouth and nose. Any handkerchiefs should be boiled twenty minutes before being washed.

2. Boil, after adding water.

3. When sputum cup containing only a small quantity of izal is half full, add an equal quantity of izal 2 per cent. Allow to stand for two hours, then empty in toilet or bury.

Faeces — 1. Mix with an equal quantity of izal, 2 per cent., or chlorinated lime 5 per cent., or acid perchloride of mercury 1-500 — one ounce hydroloric acid to three gallons of water. Stir well with a stick, leave for one hour, then bury.

2. Mix with sawdust and kerosene and burn.

Bed pans, cuspidors, urinals — Boil for one-half hour.

Glassware and rubber goods not standing heat—Soak in 2 per cent. izal for one-half hour.

Water closets, privies, basins—Scrub with soap and hot water to which washing soda is added.

Food—Burn all remnants.

Dishes, knives, forks, spoons, utensils—Put in a pan and boil for twenty minutes, and finally wash.

Blankets, linen, pillow cases—Boil for one-half hour and then wash. If soiled with blood or faeces, first soak in cold water, to remove stains, then boil.

Mattresses—If small areas are heavily soiled, scrub with 2 per cent. izal. If not stained, air and sun for six hours.

Curtains, hangings, draperies, carpets, upholstered furniture, shoes, gloves, personal clothing, pictures—Sun and air inside or outside house for twenty-four hours.

Books—Store for two weeks in a dry place, by which time all non-spore-bearing pathogenic bacteria are dead.

Hands—Scrub with soap and hot water.

Pioneer Public Health Work in Seoul, Korea

By ELMA T. ROSENBERGER

Korea, the land of morning calm, was formerly called the Hermit Kingdom, because no Westerner was tolerated within her borders; but by a strange act of Providence—the healing of the Emperor's son through the ministrations of a foreigner—forty years ago the land was opened up to Western and missionary influence, which has, in these not very numerous years, propagated itself with amazing power and speed. Simultaneously with missionary effort there has arisen medical enterprise, and the two have grown up hand in hand. In the wake of the hospitals have come the training schools for nurses, and they have flourished and given the Korean girls and women a place that they would not have dreamed of forty years ago.

Picture if you can in your mind's eye the emancipation of woman who in the early days was a prisoner in her own home, veiled, sometimes not appearing outside from year-in till year-out. This has only come by degrees, with Christianity, so steadily and so completely that today she stands up with the women of the world: among these trained nurses, some hundred strong, fully trained and equipped. By an Act passed last year the Association of Graduate Nurses in Korea has become an associate member of the International Council of Nurses.

Then three years ago came a time for the beginnings of public health work. The writer had been tied up in hospital work for two years, when all the while the canker sore of the need for public health work and child hygiene was eating at the very vitals of the soul. I saw sickness in the homes and no one to go to them and help them. I saw the unspeakable plasters tied on little babies' heads when a single remedy would have sufficed. I saw little children sitting in the open sewers in the alleys and eating the sewer filth when there was no one to cry out against it. I saw babies in homes creeping on the floor where a tuberculosis patient had expectorated. I saw babies dying for lack of nourishment and the little homes abounding in flies, and insects too numerous to mention.

At last the opportunity came for me to work. But first to plan every detail, and with limited means to

adapt a few little narrow Korean rooms and then to equip them for a new and untried work; from pins and mop rags to taking care of maternity cases on the floor in the little homes: not to mention the securing of a doctor and the training of nurses in this new branch of work. And then the weapon of the "awful" Korean language to work with. This language just two years old, transplanted on an entirely new tongue and told to explain itself and work! This is all quickly said but not so quickly done.

My assistant and I started on a cold winter morning to visit and find our way into the homes. At first we literally got cold feet because nobody understood our message; but we managed to make ourselves necessary to four homes that first day, and one little baby followed us back to the clinic. The second day two came, and so on until the newspapers wrote articles about our "self-sacrificing work." and how we were working for the mothers and children. And we did not need to seek homes any more to work in; but calls came to us, far more than we could answer.

Then in the spring, thinking that a baby show would propagate our work and message, we got ready for one, doubtful whether enough of our, as yet, "rather sceptical mothers" would come to make it worth while. Little did we anticipate the thrills and agonies of too many! For, oh! what a day! One thousand babies came; so brightly coloured were they dressed, they looked very pretty. We could not meet their needs; they wanted examinations and attention. We sent out and bought out a Japanese toy store of nine hundred toys and gave them to the babies. They wanted bread and we gave them a stone! But this just goes to prove that there is a great opening for this kind of work.

Since then the work has grown apace. It has outgrown our small quarters. We have one out-clinic in another end of the city—where the children have no shoes to come to us. We have started mothers' clubs and health classes, and we examine and teach hygiene to one thousand pupils in the day schools of Seoul each month, giving lessons and preventive treatments. We need demonstration material and more nurses to keep up with the homes that are open to us, and to prepare literature for the public.

How best and most efficiently to work is still the gordian knot in our public health work. Our vision is bedimmed by circumstances, by custom and tradition; by the overcrowded conditions in the mushroom villages; by the extremely poor housing conditions — where sometimes whole families live in a room eight feet by eight, and the streets and the open sewers are the playgrounds for the children. Where little children are carried on the backs of other little children until both are maimed and often the little one is stricken with blindness as a result of the extreme rays of the sun shining directly into his eyes.

These things are not myths and do not belong to the beautiful legends of the land. These things are solid facts and must be dealt with as such.

When we look at the beginnings of medical art in other lands and how it has been perfected through struggles, and how this newest branch of medical science—public health—with its slogan of "Prevention" is still in its developing stage even in our own country, we have faith and courage to go on with our work in Korea.

(Note—The above article was written by Miss Elma T. Rosenberger, R.N., who is at present on furlough, part of which is being spent at her home in Kitchener, Ont.)

Editorials

Difficulties of Nursing Legislation

To the members of our profession who have thought that with the passing of a Bill for the Registration of Nurses in a province nurses had accomplished all that is necessary for their protection, the present trend of affairs in one province will be a rude awakening.

An effort is being made at present by a body of medical men to amend a Provincial Medical Act "to establish a higher degree for nurses in the province; to determine the nature and extent of knowledge required; to define their duties, require their registration in a register kept for such purpose and determine the conditions of such registration."

We may well ask ourselves why this sudden desire "to establish a higher degree for nurses" when for more than ten years the nurses of that province have, with many discouragements and after the expenditure of a considerable sum of money, completed an organization which makes for standards of nursing as high as in any province of Canada. Surely these medical men — who would not interfere in any way with associations of dentists, pharmacists, etc.—will reconsider their decision and realize that by leaving the direction of nursing and nursing education in the control of leaders in the nursing profession that the standards of nursing will always be honourably safeguarded by nurses of whom Canada will always be most justly proud as she has been in the past.

However, it is pleasing to note from reports received on this situation that the Nurses' Association has the strong support of the majority of the leading medical men and of the hospital authorities of the province.

Congratulations

Well done, Winnipeg General Hospital! We wish to offer our congratulations to the Superintendent of Nurses, Winnipeg General Hospital, and the class of 1927 on the excellent showing of that class as subscribers to The Canadian Nurse. Although the members of this class are still student nurses, over fifty per cent. are subscribers to their national nursing journal, and it is expected that when the day for graduation arrives subscriptions will have been received from the entire class. This makes an excellent record which the Canadian Nurses Association would be delighted to learn was being attempted in other schools. The co-operation of the superintendents of our schools is most essential if our younger nurses are to become interested in our journal. It is realized that much loyal support has already been given by these women, a fact deeply appreciated by the Canadian Nurses Association; but there are some who may not always have stressed the fact that our nursing journal needs the loyal support of **every** Canadian nurse. Between now and the graduation of the classes, 1927, cannot there be a large enrollment of this year's graduates as subscribers, so that at a later date announcement could be made showing the schools which had achieved or nearly achieved a one hundred per cent. record?

Inter-Provincial Reciprocity in Regard to Nurse Registration

By MARY B. MILLMAN.

In order to study the question of so-called "reciprocity" in regard to nurse registration between the provinces of Canada, and to try to make suggestions for its improvement, it is necessary not only to know what provision is made in the laws of each province for the recognition of the registration of the other provinces, but also to know the law of each province which states the requirements for registration of its graduates.

Each Act regarding registration in the nine provinces has a section which reads somewhat as follows:

"Every person who resides in this province and practises or purposes to practise the profession of nursing in this province, and is a graduate of an approved training school and is of good moral character and twenty-one years of age and has passed an examination before the Board of Examiners . . . shall be eligible for registration as a registered nurse."

Also each Act has a provision similar to the following:

"Any person who is registered as a nurse in any province, state or country which maintains requirements for the education of nurses equivalent to those in this province may upon approval of the Board be registered without passing any examination."

It seems wise, therefore, to study just what educational requirements are maintained in each province, i.e., just what an approved training school is considered to be in each province. The requirements of each have been tabulated under the following heads: Preliminary Education, Length of Training, Services, Supervision, Size of Hospital and Minimum Hours of Theory (see chart).

Thus we find that technically—

Alberta can recognize none and be recognized by no other.

British Columbia can recognize none and be recognized by no other.

Manitoba can recognize Quebec and Saskatchewan, but can be recognized by none.

New Brunswick can recognize Manitoba, Saskatchewan and British Columbia, but can be recognized by none.

Nova Scotia can recognize none and be recognized by Quebec only.

Ontario can recognize none nor be recognized by any other province.

Prince Edward Island can recognize no other province nor be recognized by any other province.

Quebec can recognize Nova Scotia only and be recognized by Manitoba only.

Saskatchewan can recognize none and be recognized by Manitoba only.

In other words, there is really no reciprocity if the laws are strictly adhered to, and it would seem wise to have registration of a nurse in other than her own province less difficult than would seem possible under the present rulings.

One way possible to consider at present and one which is followed by most of the provinces, is that each nurse should be considered on her own individual qualifications and accepted for registration if she meets the standards of the second province, even if the requirements of her original province are not sufficiently high.

There is another suggestion which might be feasible. That is that the Canadian Nurses Association might conduct an examination more severe than that held in any of the individual provinces, which might be accepted by all the provinces. Thus a nurse could either write her provincial examination and if she moved to another province be in the position of probably having to write another examination, or she might write this more difficult examination and be accepted for registration in any or all of the provinces. The question as to whether any graduate nurse could write this examination or whether there would have to be a higher standard than is now set by some of the provinces, as a pre-requisite for admission to the Dominion-wide examination, would have to be carefully considered.

Although a uniform standard of laws in all the provinces may be impossible at present, this uniformity should be the objective of the Canadian Nurses Association and the provincial associations.

(Presented before the Canadian Nurses Association, August, 1926.)

Province	Preliminary Training	Length of Hospital Training	Minimum Services required in General Hospital or plus Affiliation	Supervision Required	No. of Beds	Minimum Hours of Theory recommended
Alberta	8th Grade	3 Years	Medical Nursing. Surgical Nursing. Obstetrical Nursing. Pediatric Nursing. Communicable Diseases. Dietetics.	Superintendent. Night Superintendent. Instructor. } Must be Registered Nurses.	40 Beds, with 35 patients daily average.	400 Hours.
British Columbia	2 Years High School	3 Years	Medical Nursing. Surgical Nursing. Obstetrical Nursing. Pediatric Nursing.	Superintendent. Night Superintendent. } Must be Registered Nurses. Instructor. Dept. Supervisors. Dietitian. } Recommend Registered Nurses.	15 Beds (None less than 35 beds conduct Training Schools)	330 Hours.
Manitoba	1 Year High School.	3 Years	Medical Nursing. Surgical Nursing. Obstetrical Nursing. Pediatric Nursing. Communicable Diseases. Dietetics.	Not stated.	Over 20 Beds or With Affiliation.	Not stated.
New Brunswick	1 Year High School.	3 Years	Medical Nursing. Surgical Nursing. Obstetrical Nursing.		15 Beds in Province, Outside Province, 25 Beds.	
Nova Scotia	1 Year High School required, 2 Years recommended.	2½ Years	Medical Nursing. Surgical Nursing. Obstetrical Nursing. Pediatric Nursing. Dietetics.	Superintendent. Night Superintendent. } Must be Registered Nurses. Instructor. Dietitian. } Recommended where more than 25 students in school.	50 Beds or 25 Beds plus Affiliation.	342 Hours
Ontario	2 Years High School or its equivalent.	2 Years (none have less than 3 Years)	Medical Nursing. Surgical Nursing. Obstetrical Nursing (10 cases) Pediatric Nursing. Dietetics.	Superintendent. Asst. Superintendent. Night Superintendent. } Must be Registered Nurses.	Not stated.	304 Hours
Prince Edward Island	8th Grade.	3 Years	"General Training."	Superintendent. Operating Room Supervisor. } Must be Registered Nurses.	50 Beds.	340 Hours.
Quebec	1 Year High School	2 Years	Medical Nursing. Surgical Nursing. Obstetrical Nursing. Pediatric. Nursing	Superintendent. Night Superintendent. } Must be Registered Nurses.	50 Beds.	303 Hours
Saskatchewan	1 Year High School (recommended)	3 Years	Medical Nursing. Surgical Nursing. Obstetrical Nursing (12 cases) Pediatric Nursing.	Superintedent. Night Superintendent. Instructor. } Must be Registered Nurses.	30 Beds Daily average 20 beds.	401 Hours

How to Provide a Sufficiently Broad Training and Experience for the Pupil of the Small School

By HARRIETT MEIKLEJOHN.

Sound health is conceded to be the most valuable asset of any country, yet it seems that we work slowly in the development of some of the most valuable means of health control, i.e., Schools of Nursing. Canada needs population, above all, rural population, and it would seem wise to develop such services as will make for safe living in rural and urban communities. Human lives should be of equal value and call for as expert service in health and disease in one community as another.

There is no one body of people who can better assist in the prevention of disease and the care of the sick than can the well-prepared graduate nurses of today; but what percentage of the graduates coming from the smaller schools in Canada has had the broad training and experience necessary to equip them for the best results to the country? There are many splendid small hospitals with their training schools in the Dominion, but there is still vast room for development both in hospitals and schools of nursing.

Small schools of nursing should be made of greater importance in their communities, which in turn entails the development of the hospital itself. This may sound like putting the cart before the horse, but in the case of so many of the small institutions those in control are too content to develop: content that a place of comfort has been provided for the sick, no matter how limited; content with a training school which functions with the minimum of expense. Content to feel that what they do not handle will be cared for by the hospital of the nearby city. This attitude of the hospital sometimes results fatally to the patient and it certainly limits the training of the student nurse.

Nursing in the small hospital can be as expert as in the large. It is not so much the number of cases which comes under the observation of the nurse in training which is of primary importance, but the diversity of cases and services, the technique and method of teaching. Most of the smaller hospitals could throw open their doors to a much greater variety of service if the purpose in self-development and the consequent benefit to the community could be understood.

There is no one service that is of greater value in developing a community than an efficient service in health and disease: a service which impresses an intelligent community with a sense of confidence and security in the time of their greatest need.

The question of affiliation for the students of small schools (i.e. affiliation away from their immediate community) versus local development, has always been an interesting one. In the opinion of the writer local development is the better line to follow and, except in unusual cases, it is practically always capable of accomplishment, given the will and the energy. It is better in every way for the life and future of the community, and is frequently the means of saving the life of the individual.

The hospital and the training school should be made **the** important institution in a community. The matter of the education of the nurse; the training and experience due her for her three years' service a matter of first concern to the boards of governors, the medical staffs and the public. The value of the well-conducted, efficient school of nursing to the community is hard to estimate but easy to demonstrate. The fact that the probationer should be entering a

SCHOOL of nursing has penetrated into the minds of few of our boards or medical staffs, much less is it appreciated by the general public. When **this** point of vantage is once gained things begin to move: boards realize that a SCHOOL must have equipment, esprit de corps, and so forth. The medical staff take a keener interest in the school when their point of contact is professorship. The school begins to grow.

The school of the small hospital can be made very attractive and quite worth-while even to the high school graduate. Often the small hospital can show a variety of cases seldom seen in a large city institution, and the pupil can receive an individual supervision impossible in the larger school.

In our present experiment—let us call it that, as many of our ambitions with regard to the school have not yet been realized—in 1924, we had a school of twenty-five pupils, and the hospital a mixed service of about sixty-five beds. By September 1st of this year, because of the rapid development of the past two years, our school will number fifty. We are beginning to take on the aspect of a real school. The bed capacity has increased to one hundred, and services are beccming gradually defined as hospital space permits. There is a fine maternity service covering some three hundred cases a year. Frequently a student registers over forty cases in the labour room. A children's service, small but complete (10 beds) and attended by a most competent pediatrician. The first year showed an admission list of one hundred children under six years of age, with diagnoses covering all types of cases. In order to obtain public confidence and give the service a start, admission fees for children were put at a very low rate. This, too, enables parents to pay for their children and they are not forced back upon the city for aid. The students are very keen to have this service, and feel that they are gaining a most valuable insight and experience from it.

A tonsil and adenoid surgical clinic admitting from one to twelve cases daily has been established. Students have a term there after their operating room service, and are taught the story of the tonsil and adenoid from the public health aspect, and become familiar with the after cure.

A former head nurse has recently undertaken a very fine demonstration. She has taken charge of the twenty-five bed sanatorium for tuberculosis at St. Catharines, and our students are now able to affiliate for that special service. This institution is distinct from the general hospital except that the school has the privilege of supervision of the training of the students while on duty there. The sanatorium expects to enlarge to fifty beds in the spring, after which it is hoped to include the students of the other small hospitals round about in the affiliation. This is a three months' service: two months at the sanatorium, one month spent with the public health nursing and visiting nursing staffs of the city, observing the efforts of other organizations to prevent the individual from requiring the service of the hospital.

In addition to the required lessons in diet cooking, the entire cooking and food service of the hospital is directly under the students of the school, of course under the constant supervision and instruction of the dietitian. It is planned to grade this service so that each pupil will receive a minimum amount of time on each type of diet, and understand the ordering and storing of foods.

The subject of laundry is taken up from points of efficiency and economy. The mortuary has been so appointed that classes may attend post mortems, and additional instruction in anatomy and physiology is given by the pathologist in charge.

Every student in addition to classes and demonstrations receives a term in laboratory, X-Ray, hospital supply room, hospital office and administration.

Medical, surgical and gynecological services with operating room are

adequate as usual in the small hospital. The hospital for contagious diseases will soon be controlled by the General Hospital. The ambulance service of the city is to be taken on by the hospital shortly, and some time in the future it is hoped there may be accommodation for all clinics and public efforts being carried on by the local health authorities. At present the chest and V.D. clinics are established.

Probation classes are admitted twice yearly for a four months' period. A full school curriculum, according to that most valuable aid, The Minimum Curriculum of the Province of Ontario; eight-hour duty for night and relief nurses, and all but nominally for the day staff; a fairly broad range in services; two vacations of four weeks each for pupils, have been developed in less than two years in one of the so-called "slow" towns of Ontario.

When 1928 comes this small hospital should be graduating nurses who will have a broad understanding of health and their personal responsibility in its community conservation, as well as nurses who have had a liberal training in the care and nursing of the sick.

Note—Since the above article was read by Miss H. Meiklejohn at the Nursing Education Section of the Canadian Nurses Association general meeting, in August, 1926, the St. Catharines Isolation Hospital has been opened. Also, during December, 1926, a campaign was organized to raise $175,000 for a new wing to accommodate sixty more beds. Within a few days the objective was reached, and at the close of the campaign it was found that $218,300 had been raised. This development of the St. Catharines General Hospital is interesting to nurses, who will recall that the General and Marine Hospital, St. Catharines was the first in Canada that succeeded in establishing a school of nursing, through the efforts of Dr. Mack, who in 1874 sent to England for two trained nurses and five probationers and founded a school that has always been worthy of the name.*

*(Outlines of Nursing History—Goodnow, page 171.)

The Canadian Tuberculosis Association

During the present year the Canadian Tuberculosis Association is emphasizing the following:

1. The value of ample nourishment and visiting health nursing supervision of children (contacts) in homes having cases of tuberculosis.

2. The same help for children below par in weight, etc., found by medical inspection in schools.

3. The provision of open window schools, serving milk and providing rest periods morning and afternoon.

4. Training in h e a l t h habits (Junior Red Cross or otherwise).

5. Ample s u m m e r camps for mothers and pre-school age children, as well as camps for children under health supervision.

6. Complete medical examination every birthday, which might detect disease in the "flappers" in its early curable form.

7. Support of Mr. F. L. Hoffman's three provisions to keep the children healthy when they enter industry: but 40 hours work in four days as a total week's effort is reported as creating family hardship in Canada.

Mr. Hoffman states that in his opinion the t h r e e outstanding reasons which to a large extent explain the actual and relative decline in the pulmonary tuberculosis death rate are:

a. Higher wages, giving better nutrition and building up bodily resistance.

b. Shorter hours, preventing fatigue and giving better opportunities for outdoor life and recreation.

c. Better shop hygiene—improved conditions of air and ventilation, light and sanitation.

The Post-Natal Visit: Its Opportunities

By M. I. PETERS, Victorian Order of Nurses, Montreal

Post-natal visits afford the nurse the opportunity to further impress upon the mother the lessons taught during the puerperium, and to help her to make the sometimes difficult adjustments whereby the new baby is fitted into the family life. The mother should be made to feel that the visit is of a helpful, friendly nature, not merely part of routine work.

The temperature and pulse are taken and the mother's health and diet discussed. She is instructed not to do any heavy work for six weeks after the baby is born as it takes this length of time for the uterus to return to its normal size. The importance of a fifth week examination by the doctor should be explained to her, pointing out that this is the only means by which the condition of the perineum, and whether or not involution is complete can be ascertained. She should be advised to lead a quiet, normal life and to rest a certain length of time each day, as an overtired mother becomes irritable and will have a fretful baby. The mother should lie down while nursing the baby as this will give her a chance to rest and is very comfortable for the baby. The breasts should be examined to see if the supply of milk is sufficient: if not, instructions are given as to how it may be increased. Encourage her to keep the baby on the breast, never give a formula without first consulting the doctor, and discourage the use of proprietory foods, explaining to the mother why they are not as good as breast milk or cows' modified milk. Advise the mother to eat plenty of good, nourishing food: such as eggs and vegetables, and to drink milk and plenty of water; not to hurry her meals but to try to take time and eat slowly. The importance of the regular evacuation of the bowels should be discussed, and the patient advised to consult her doctor immediately should any abnormal conditions arise.

The baby should be weighed and enquiries made as to his health, intervals between meals and how long kept at the breast. The mother should be advised to nurse from one side only and to empty breasts alternately unless there is not enough milk, when both may be used. The importance of completely emptying the breasts as the best method of maintaining milk supply should be dwelt upon. The normal baby should nurse every three hours during the day and at 10 p.m. and 6 a.m. and should not be disturbed for the 2 a.m. feeding if sleeping. If not fed regularly the baby will have indigestion. Cool boiled water should be given between feedings. Enquiries should be made as to the colour, regularity and nature of stools, and the nurse should see that the umbilicus is properly healed. The baby should be bathed at the same time every day, preferably before the 9 a.m. feeding, as it is most important for the baby to be taught regular habits. The baby should sleep by himself, have plenty of fresh air and sunshine and should not be picked up every time he cries, as bad habits are very quickly formed. If the doctor is agreeable the mother should be advised to take the baby to the nearest public health centre; and also, if the birth is not registered she should be urged to have this done as soon as possible, discussing the reasons for this most important measure.

The first post-natal visit should be made three days after the patient has been dismissed for nursing care, and then weekly up to the fifth week. When making these visits the nurse should notice the condition of

the other children in the family and give the mother advice as to their health habits, recreation, etc. If any abnormalities are noticed they should be attended to at once. If unable to afford a private doctor, clinic treatment should be arranged —children of pre-school age being referred to the nearest pre-school clinic. Short talks may be given on the diet of the children, sleep habits, necessity of sunlight and fresh air, pointing out the opportunity now afforded all for protecting children against communicable diseases by the use of vaccines and serums that have been found to convey immunity. Instructions should also be given in regard to home sanitation and ventilation.

The nurse's aim should be to make every effort to secure for the mother and babe the maximum of health and to leave the family better in some way because of her visits.

One Case of Scarlet Fever

By a Victorian Order Nurse.

A typical February day—damp and windy, flurries of snow, a one-hour's ride in a street car poorly ventilated and none too warm—a walk over streets only partly cleared of the recently-fallen snow, to a tiny house set far back in a field, well outside the city limits. This was my introduction to a new "scarlet fever case."

Such a place to be called "home" by six human beings—three grown-ups and three children, the youngest seriously ill with scarlet fever! It is called a three-roomed house, but consists of a tiny kitchen and double-parlour, the back part of the latter having neither light nor ventilation from outside. The whole place is dark, dirty, and full of all the odors of the winter produced by cooking and by breathing, perspiring humanity in a small space unaired during the cold months.

Where to leave bag and out-of-door clothing! According to instructions, these things are to be left in the room farthest from the sick room, and where the children will not reach them. That most nearly meeting these requirements was the kitchen. So, taking a chair, carefully protecting it with a newspaper, I removed hat, coat, gloves, and cuffs, and placed them neatly on this. After protecting a corner of the kitchen table with another paper, I set my bag there, and removed the articles I would need in the morning's work and turned towards the rooms beyond. Just then the door opened, and in hurried a woman laden with parcels. With one sweep of her arm she cleared the table of my things and spread her purchases out in their place. At the same time, an eight-year-old, in his eagerness to inspect the parcels, bumped against my chair nearby, upsetting it, too, on the floor.

Order restored, I went in to the patient. Here beside her mother in a large double-bed lay a tiny three-year-old girl, seriously ill. The other furnishings consisted of a single cot and a large dresser, practically filling the room. I could just squeeze between the cot and bed, and when it was necessary to visit the cupboard for clean linen, the dresser was pulled aside, things removed from the cupboard, the door closed and the dresser pushed back before I could get out of the corner again. In the other end of the double-room was

what appeared to be an old-fashioned chest of drawers. Later I found that the front "unhooked," and on being lowered, provided sleeping accommodation for the father and the two boys, one eight and the other ten years of age. I also learned that during the night the little girl was lifted on to the couch and the "lady of the bundles" slept in her place beside the mother.

While these observations and preparations for care were being made I was busy trying to explain the reasons for the extra precautions, and asking for basin, water pitcher, towels, and other needed articles; but alas! the family spoke no English, and I very little French. However, with my halting French, and gesticulating, together with a willingness on both sides to try to understand, wonders may be accomplished. The eldest boy was not at home. I thought, perhaps, he was out playing in the snow, but, no; he had gone to church. The mother was horrified when I suggested that he was most likely spreading fever germs through the community. This was a very decided difficulty to overcome as the family was completely lacking in any feeling of community responsibility. All the household had been ill so they themselves were safe—so why consider others?

Rather than discontinue her shopping and visiting among her neighhours the second woman in the household moved away and no longer comes to the placarded home. The over-crowding is thus much diminished, and the father is quite able to do the marketing. The mother, relieved of part of her care by the nurse's daily visits, can devote more time to tidying and cleaning up the home. And I am hoping soon to see a window open and a little fresh air taking the place of the stagnant atmosphere there now. This, with the steady recovery of the child, repays in a very great degree the cold, discomforts, and difficulties of my early visits here.

Opportunity

Marjorie was the eldest of four. She was a thin, pale little girl. Her mother did not think much of Marjorie's paleness, thought it was only natural, as she was growing so fast. One day a V.O. nurse met Marjorie and her mother. In talking the nurse asked if Marjorie was cold, she looked so blue and pale. "You know, nurse, she has no appetite and gets tired very easily, but I think it is only because she is growing so fast." "Have you taken her to see a doctor?" "No, I haven't. You see my husband is out of work and we cannot afford any extra bills." "Well, why not take her to a hospital clinic? There you will get the medical advice you need. I will give you a note for the clinic."

A few months later the nurse met the mother again. "Oh, nurse, you should see Marjorie now; she is in the country and it is a pleasure to see her rosy cheeks and watch her play. I want to thank you,—but for your timely advice, and a little slip of blue paper, I would have no little Marjorie to-day."

Our readers' attention is drawn to the announcement appearing on page 157 of this issue, in reference to the etching of the Memorial Panel, Canadian Nursing Sisters, and to the scholarships offered by the Victorian Order for Canada.

Department of Nursing Education

National Convener of Publication Committee, Nursing Education Section,
Miss EDITH RAYSIDE, General Hospital, Hamilton, Ont.

*Round Table: Instructors' Problems**

The papers presented for discussion at the Instructors' Round Table included one on Teaching Problems by Miss Mary Black, Instructor of the University Hospital of Alberta, Edmonton; and one on Problems of Instructors by Miss Mary Pickard, Instructor, Royal Victoria Hospital. Miss Olga Lilly, Instructor, Montreal General Hospital, read a paper on Case Study as a Means of Teaching Nurses to Teach Themselves, and Miss Kathleen Scott, Instructor, Toronto General Hospital, discussed the Clinical Method of Teaching.

Among the problems considered were: How to meet the criticism of the present day curriculum; how to correlate theory and practice; the training school budget; the youthfulness of the student nurse; the over-crowded curriculum.

During the discussion following the reading of papers, many questions were asked in reference to the Clinical Method of Teaching. Miss Gregory-Allen, of the Royal Jubilee Hospital, Victoria, and Miss Lilly, of Montreal, described the use of this method in their respective schools. The Case Study Method of Teaching was also discussed with interest. Copies of studies made by students were shown, and many questions as to the number of cases to be studied and how the student gathered the necessary information for the Study, showed the interest of the meeting.

The problems presented in the first two papers were not discussed, owing to lack of time.

ETHEL M. SHARPE,
Chairman.

Teaching Problems

By MARY BLACK, Instructor, University Hospital, Edmonton, Alta.

"Teaching is the art by which the right people teach the right thing at the right time and in the right place." One of the most important functions of the nurse is that of teaching, directly and indirectly a health teacher to the patient, to her fellow students and colleagues, and to the community and to the state. As the calling of the nurse carries with it this public duty, the first essential in teaching student nurses is the right person as teacher; secondly, the right teaching material, taught at the right time and in the right place.

I would like, therefore, to consider this subject of Teaching Problems under a large heading — Teaching Equipment, and under Teaching Equipment I would like to consider: first, the hospital; second, the student, and third, the teacher.

1. The hospital equipment should consist of a hospital of good character and standing in the community. By its traditions it teaches indirectly as well as directly, commanding public respect and confidence, with a certain dignity. Because it selects with great care its officers, staff, physicians and nurses, it is able to meet its obligations. Newly founded hospitals too often

(The Nursing Education Section, C.N.A. General Meeting, August, 1926.)

lack the dignity and traditions which older institutions enjoy—and here is a real problem in teaching.

A basic teaching problem in schools of nursing is that of the budget. Could it not be financed by public funds—taxes, grants, etc., as other schools and colleges are? It is granting a real service to the community and should receive its support. A tuition fee should be charged the student too, as in any other school. If our nursing education is worth anything, it is worth being paid for.

In the hospital equipment might be classed as the clinical resources. Is the teaching field an active one? Has it from 16 to 20 patients per bed per year? One private patient to four free patients? If it has not medical, surgical, children's, obstetrical and communicable diseases departments, has it good affiliations to provide these fields? With the medical field, are there also nervous and mental diseases? Besides surgery, there should be ample opportunity for gynaecology, orthopaedics, operating room technique, emergency and out-door. The children's service should consist of school nursing, dental nursing and public health nursing. A hospital affiliated with or owned by a university has a very rich teaching field in that it is pervaded by a student atmosphere, and has a share in the knowledge, research, science and equipment of the university. The hospital wards are the laboratories of the student where the lessons taught in the class room are put into practise.

The class room is the last thing thought of in many schools of nursing. How many students would consider a university or any college of higher education an efficient one if there were no class rooms? A good class room or lecture room should be part of the hospital teaching department, which should also include an instructor's office, demonstration room, library and study room. The class room should be well aired and ventilated, lighted from the left and back of the student. Good seats, comfortable (but not comfortable enough to encourage lounging), should be provided. Other assets are a daylight screen, slides, lantern, a good slate blackboard, teacher's desk, clock, skeleton, bones, coloured crayons, posters, models, specimens, popular health literature, maps, reports, records, charts and exhibits.

An office for the instructor, in which she may study, prepare her lectures, keep her records, correct assignments and interview her students privately, is excellent.

The demonstration room, too, should be equipped as in any school of higher education. Because the students are first taught here what they are afterwards expected to do on the wards (laboratory), it should as nearly as possible be fitted with equipment which would be found on a ward. A simple demonstration room should contain the following: four to six beds, with complete equipment (chair, locker, linen); blackboard and chairs for students, mannikins, a linen cupboard or room, a medicine cupboard and a utility room.

Students should be grouped so that there are not more than 8 to 12 students at a demonstration. Students or patients are best used as subjects when possible.

The size of the library is not important, but the best books on a wide range of subjects should be found there. Reference books should be loaned over night only, students returning them each morning. This is fairer to each student and works well.

The study room, especially at the advent of each new class, should be well supervised. Special classes

should at first be given on "How to Study," along with excursions to the library. Silence should be insisted upon at all times in the study room.

2. In considering the student, one of the first problems is hours of duty, and this problem is still having severe growing pains. Our students are required to do two things at once—study and classes, and care for the patient. The patient, being real and vital, comes first, and classes held during the term while the student also has the care and responsibility of the patient cannot receive the undivided attention of the student. If our student nurses could have their theory, followed by hospital laboratory, their undivided attention could be then given to both. As it is at present, the student has not time for study, is physically and therefore mentally tired and must give only half her attention to her class.

The youthfulness of our students is one of the greatest present day problems. Hospitals are increasing so rapidly and so many students are needed that it has become the fashion to become a student nurse at 18 years of age. The profession will soon realize that it must foster a few good schools and produce good nurses, rather than many schools of questionable quality, producing all grades of nurses. Nursing is a profession. All other professions insist upon a four-year high school preliminary education, and then four, five, six and seven years at a university after that. Some such high standard as this will have to be insisted upon by our profession if we ever hope to raise our standard to that of a profession.

In considering the curriculum, which is so overcrowded: Pre-nursing subjects on the high school curriculum, such as languages, history, mathematics, physical training, music, drawing, voice culture, and the elementary sciences, including physics, chemistry, physiology and household science, if included in the student's elementary education would relieve this congestion.

A few of our largest and best schools connected with our principal universities offering a course in nursing would produce nurses of such a high standard that soon so many worth-while women would be attracted to the nursing course that perhaps the "Faculty of Nursing" would become quite as crowded as other faculties have become. Smaller hospitals would function as hospitals only, and they would be manned by graduate nurses who know their work and are qualified to give real service to the patients who come as guests to the hospital.

A separate theoretical and laboratory course would necessarily be longer than the present three-year course. But, if the course were four years the students would be older when given responsibility. Their characters would be well developed, physically, mentally and morally. They would not be so rushed with both kinds of work at the same time. Illness would not be so rampant, nervous breakdowns could be prevented, and the new environment, not being thrust upon the young woman so quickly would not be so apt to bias and cramp her vision of life. The law of apperception holds good in the teaching of nurses as in that of other students. They must be led from the known to the unknown. If led too quickly their conception of life is apt to be rather starved and ideals too often shattered. It does not develop the broad viewpoint. A student on entering the nursing school has usually the highest of ideals, which must be fostered and developed. The young nurse should be encouraged to seek for her motive, that of taking the most useful tools in the race's workshop, and by trial and effort learn to use them in such a way as to go on perfecting her skill in their use

as long as she lives. If she is to learn anything she must put herself in the way of learning it. She must have the desire. The circle of knowledge is but a guide to help her exercise mastery for herself.

3. The teacher: Goldsmith recognized skill as the great attribute of a teacher when he said:

"There in his noisy mansion, skilled to rule,
The village master taught his little school."

Skill is a development, because of a thorough preparation. A well prepared teacher is an educated woman, with a broad point of view, with intellectual capacity and a desire to improve. Her education may consist of the following: 1, elemetnary, high school and university; 2, three years' study in a good nursing school, for she must be expert in demonstrating, as she must practise what she teaches. It is said of Florence Nightingale—"In all her personal work as a nurse she was peerless, satisfied with nothing less than perfection;" 3, normal training — experience and training in teaching is essential; 4, public health point of view—preferably a course in public health; 5, the instructor's course—over and above this a good teacher of nursing should constantly refresh and supplement her knowledge by study, observation, excursions, new schemes, new ideas, school visiting, attending conferences and conventions. She should be interested in research and should also have outside interests. A knowledge of the History of Nursing is an essential background for all teachers of nursing, no matter what form it takes. Good literature should constantly be read to enrich her vocabulary and improve her English. She should be studious and anxious to grow. Strayer writes: "A teacher who is anxious to grow will avail herself of the opportunity to teach a demonstration lesson." Applying this to our teachers, let us ask ourselves: How many are anxious to grow?

Equally with skill should be included another attribute, personality. A personality to command the respect and confidence of her associates, a leadership to establish democratic relationships, a dynamic human interest, and an attractive sterling character, with enthusiasm. Such a personality assists the teacher to see her opportunity as a teacher in relation to her students, and to be a good judge of people.

The following are some of the attributes of such a personality:

An inward and spiritual grace, a cultured voice, good physique—vigorous health. A teacher of health must first be healthy.

She should have good poise, no noticeable deformity, be business like, and her dress should be a plain uniform, no jewellery nor brightness to attract attention.

While the teacher must remain the leader, she should strive to make herself as unobtrusive as possible, and yet retain a degree of firmness.

The student should be helped to find a joy in her work, to feel the need of suggestion, to develop creative self expression, to be educated as well as trained, to be stimulated to her best efforts. To accomplish this, the teacher must not forget to be approachable. Do her students seek her help?

With such qualifications, it is readily seen that the nurse teacher of today truly can neither be too wise, too womanly, too highly trained nor too good. Such a teacher in the right time, and in the right place, and with the right people would no doubt produce a responsible, self-reliant, self-respecting, intelligent and devoted nurse.

She should strive to possess an ability and desire to impart knowledge, patience to develop a student, a willingness to repeat, respect for the opinions of others, faith in her students, a keen and sympathetic understanding of their problems.

The day's lesson should in every instance comprise but a small fraction of the teacher's knowledge of the subject. Such a knowledge of the subject requires preparation, so as to direct the student to deeper sources of knowledge, wisdom and inspiration.

Hospitals should demand thoroughly qualified teachers, and a premium should be placed on efficient service. The profession of nursing needs to regard itself more highly as a profession, instead of a business. It needs to look upon its life work as a means of service as well as a means of livelihood, as a calling rather than a trade, for "Nursing is an art — the finest of fine arts." Having developed such an ideal of service, our reward will truly be joy in that service.

Problems of Instructors

By MARY PICKARD, Instructor, Royal Victoria Hospital, Montreal

The public school teacher has her problems. She must maintain discipline but at the same time she must gain the confidence of her students. Further, she must please the parents, the school inspectors and the board of trustees. But above all she must teach the students in a manner that will satisfy her own highest ideals.

Instructors in nursing, especially if they are trying to follow an up-to-date curriculum, have all the problems of the school teacher, with many additional ones. It is hoped that a discussion of the following three will be of interest: First, criticism of the present-day curriculum; second, failure of student nurses to carry out on the ward the instructions of the teacher; and third, correlation of theory and practice.

Criticism of the present-day curriculum: We believe that nursing in its highest form is both a science and an art. Science implies knowledge and art implies skill; both are needed in nursing. Because of the feeling among those most deeply interested that the science side of nursing needed development has come our enlarged curriculum, giving a scientific basis for our art. These are so linked together that the one reaches perfection only with the other. But this advancement has brought another problem to the instructor.

The rather popular idea, not only among many doctors and members of boards of management but even among graduates in charge of wards, is that the nurses trained under the present regime are lacking in the true spirit of nursing and it is feared by these, with the increasing hours allowed for study, that not only will the students be unable to care skillfully for the sick, but that they will be usurping the work and authority of the doctor. With the eight hours' work on the ward daily, surely with the intelligent distribution and supervision of the work the student during three years can learn to care deftly and skillfully for the sick.

As to nurses knowing so much that there is a danger that they will usurp the work and authority of the doctor—the curriculum falls far short of that. It has been drawn up to provide each student with a good working knowledge of the profession. "A little learning is a dangerous thing." Never more aptly quoted than in relation to nursing. A nurse giving a treatment or medicine must know what result the doctor expects from that treatment or medicine; not that she may change the order but that she may give intelligent co-operation.

Education has nothing to do with killing the true spirit of nursing. In the olden days there were nurses who were inspired with the true spirit of nursing, the Florence Nightingales and Sarah Gamps. To-

day we have nurses belonging to both classes. But the nurses who are thoroughly equipped with knowledge are able to give better service and more wisely directed sympathy.

Co-operation of students on wards with instructors: From time to time complaints are heard that student nurses fail to do their work on the wards as they are taught in the classroom.

The instructor feels that she has taught methods and the theory underlying these methods so carefully that the student should know exactly how to perform each step, and yet much to her chagrin when making rounds, she finds the student improvising methods and equipment, sometimes effectively, more often not. Nor is this digression made only by the dull nurse but often by the bright one. If the student beyond being reprimanded is questioned as to her reason her reply may be: "I didn't have time" or "I didn't have the things to work with," or "I find this way easier." We do well to consider whether the methods as taught are the best. Have we with others reviewed and considered the exact course of procedure or is the method the product of one brain, or has it been handed down from one to another? Never let us be supporters of the doctrine behind which so many hide their inertia: "What was good enough for our fathers is good enough for us." The doctors in their profession have not taken this attitude, nor must we. We must be critical of our methods and welcome the constructive criticism of others until we have so changed that we feel our ways satisfy as nearly as possible the demand of ideal methods: that is, 100% safety for patient, 100% efficiency, 100% economy of time, 100% economy of material and 100% economy of effort for both patient and nurse.

The ideal method having been established, the co-operation of the students must be gained. Strictest discipline with severe punishment might be found satisfactory in some work, but where the student nurses are left to a large degree to act as their own monitors, without an honest co-operative endeavour, laxness is bound to occur.

Since it is agreed that uniformity of method is desirable both for the mental and the physical comfort of the patient and the well being of the school, co-operation is essential. The modern trend leaves room for the expression of the individual and loudly condemns the attempt to make machines of the workers. How are we to have uniformity in the school and yet leave room for originality? We could encourage the students to bring to the class for discussion any new ideas or questions or suggestions, where they could be discussed. If these suggestions were found to be practicable they could be adopted. At the same time the student must be made to realize that while the methods as taught may not be infallible yet they have been prepared carefully and scientifically, and the student must understand that it is both unsafe and wrong to change any procedure without conferring with someone in authority.

Let us gain the confidence of our students. Someone has said that an instructor could know that she was doing good work when her students came back to her for further advice.

This is a big undertaking, but the instructor is not the only teacher. The supervisors, head nurses and senior nurses are all willing to assist, especially if asked for definite help and made to feel that their assistance is essential. The instructor could help to ensure a spirit of co-operation with the head nurses by showing her willingness to arrange the classes to the best of her ability to make the ward management easier.

Correlation of theory and practice: This is an ideal difficult to obtain, but the use of case studies and bedside clinics are a great help. Demonstrations, too, are wonderfully helpful and interesting. Sometimes the arrangement is left in the hands of a class of students. The school, including the staff, is invited to witness the performance and no lack of interest is manifested. If medical lectures are being given then medical treatments are shown, e.g., the treatments, medicines, etc., from beginning to end of a typical case of pneumonia are demonstrated. The performance serves as a lesson to some students, a review for all, and inspires a spirit of productive rivalry and greater skill on the part of the students.

(This discussion will be concluded in the April number.)

Speaking at the annual meeting of the Alumnae Association, St. Boniface Hospital, Manitoba, the retiring president (Mrs. McLeod), said in part:

One thing I do think—and I am taking this opportunity to say so—is that I do not believe our graduates realize the importance of the Alumnae Association and what it stands for. First of all, it is the arm that reaches out from the school, or Alma Mater, to the public and the world at large. When attending a large convention of nurses, as I had the privilege of doing last summer, one realizes the advancement in the nursing world or profession, and to keep up with that advancement one must first of all be an enthusiastic member of one's Alumnae, and have that association represented at all important meetings of nurses. We all realize the necessity for registration. If, as graduates, we do not register, we are shoved to one side and forgotten. Hence, the importance of belonging to our Provincial Association. It all takes time and money, but when we stop and consider what the pioneers of the profession did, and are still doing—for many of these noble women who put their foresight and thoughts into action are still active in the work and are keeping the wheels of progress turning—it should give us courage to carry on. They cannot go on for ever, and many of our younger ones are working hard and giving their best for our profession. Don't let our Alumnae be a dead number! I know we have the material and the ability to follow in the footsteps of these pioneers, as officers and co-workers with other schools in the Dominion. I would ask that our younger members, and all members, prepare papers on some subject pertaining to nursing, or the work being done by nurses in the many different branches of the profession: these papers to be read at our own meetings, if for nothing more than practical training, to be put into effect in other meetings. Expressing your views and entering into discussion at our own meetings gives you confidence and self assurance, which we all need. The sound of our own voices often frightens us.

We are electing an entirely new executive this year, and I am sure they will receive the hearty support and co-operation of the members.

A Nurse's Prayer

Guide Thou my hands, that e'en their touch may prove
The gentleness and aptness born of love.
Bless Thou my feet, and while they softly tread
May faces smile on many a sufferer's bed.
Touch Thou my lips, guide Thou my tongue,
Give me a word in season for each one.
Clothe me with patient strength all tasks to bear,
Crown me with hope and love which know no fear.

Department of Private Duty Nursing

National Convener of Publication Committee, Private Duty Section,
Miss AGNES JAMIESON, 38 Bishop St., Montreal, PQ.

Post-Operative Vomiting

By DR. R. E. VALIN, Ottawa

Probably no complication will prove more annoying to the patient and more trying to the nurse than post-operative vomiting following abdominal operations, the causes for which may be discussed under the following five headings: (1) anaesthetic vomiting; (2) acidosis; (3) ileus, paralytic and mechanical; (4) morphia; and (5) acute dilatation of the stomach.

Following a general anaesthetic, a patient is likely to vomit, especially on returning from unconsciousness, perhaps bringing up a little bile-stained mucus, but if the anaesthetic has been judiciously given this soon ceases.

Occasionally, however, the vomiting persists for some time. This is due either to the ingestion of mucus mixed with ether causing a local irritation of the stomach or else from a central irritation causing reflex vomiting. This may be checked by giving a long drink of bicarbonate of soda, which will probably be vomited but will act beneficially by washing out the stomach.

In more severe cases it may be checked by administering tincture of iodine in drop doses. As a rule all administration of food by mouth should be stopped until the vomiting has ceased and if necessary nutrition maintained by rectal feeding. This form of vomiting is looked upon almost as physiological vomiting.

Acidosis may be described as a depletion of the alkaline and carbohydrate reserve of the blood, manifested by persistent vomiting and dehydration of the system and by the appearance in the urine of acetone and diacetic acid. It is a disturbance in the metabolism of the body, and is attributed to several factors. The food intake, especially the fluids, previous to a surgical intervention, have been limited.

During the operation, through perspiration and as a result of anaesthetic vomiting, considerable body fluids are lost and the glycogen reserve of the liver is rapidly depleted. The body must now derive its heat energy from the fat and protein of its tissues. In the presence of insufficient carbohydrates, combustion of fat follows, and then intermediate products of fat metabolism, i.e., acetone, diacetic acid, accumulate in the blood stream.

What are the clinical symptoms of acidosis? Recall the patient, the day following operation or perhaps continuous with anaesthetic vomiting, who vomits almost persistently, holding a basin to his lips constantly; large quantities of watery mucus and bile are brought up, without much effort, without abdominal pain and without distention, unaccompanied by any elevation of temperature, and the bowel movements may be normal with an enema. Large quantities of fluid are vomited and the patient rapidly becomes depleted and dehydrated. The lips become parched from this acid vomiting, which may persist for two or three days or even more, and may lead to a fatal termination. It is threatening the life of the patient

(Read before the Private Duty Section, C.N.A., General Meeting, 1926.)

and proves most trying to the nurse as she observes her patient becoming more and more distressed in the presence of such a persistent complication.

What is the treatment? Since the condition is due to an insufficient supply of carbohydrates (sweets), the administration of this substance results in prompt disappearance of the acidosis and a return of a carbon dioxide containing power to normal values. Glucose is given by mouth if the patient is able to retain it; most of them cannot. Most satisfactory results are obtained by the intravenous injection of 10% glucose solution chemically pure in normal saline solution. The results are striking and usually follow one intravenous injection. Vomiting stops, restlessness is allayed and the patient experiences a considerable measure of subjective relief. Insulin has been advocated, but it has no advantage over the administration of glucose.

The third condition, which is still more serious than the previous two, is ileus, or intestinal obstruction: a condition in which the onward passage of feces is prevented. As a result of ileus there are the following symptoms: (1) coprostasis, or retention of feces, i.e., constipation, fermentation, with meteorism or gas, distention of the abdomen as a result of decomposition of the intestinal contents; (2) pain due to the peristaltic movements of the intestines trying to force its contents past the block. These pains are quite severe; (3) regurgitant vomiting, which is the predominant element; at first the gastric contents alone are ejected, but later the vomit becomes bilious and even stercoraceous or fecal; (4) nervous phenomena, in which the patient suffers almost at once from shock, which passes off after a time, and later from a collapse due to toxaemia; vomiting and hiccough develops rapidly, and this latter sign is looked upon with grave suspicion and is an omen of bad import; (5) if not relieved, the condition will end in death, due to toxaemia or perforative peritonitis.

The causes of paralytic ileus are usually from a diffuse or localized acute infective inflammation as peritonitis or acute appendicitis, and usually are met with after surgical interventions. Whereas the causes of mechanical ileus are: (1) strangulation by bands of adhesions; (2) intestines kinked by bands; (3) twisted on its own axis, this is volvulus; (4) invagination of the bowel or intussusception; (5) hernia; (6) malignant growths, etc.

In this condition of ileus, in marked contrast to the first two, there is vomiting, pain, distention of the abdomen, tympanites, obstinate constipation, leading up to acute obstruction.

Enemas are ineffectual, no flatus is expelled—much less fecal matter. The enema may even be retained with vomiting of the duodenal contents.

These signs are suggestive of a very serious abdominal storm, one which must be recognized early, before the patient subsides into a state of collapse, as early surgical interference is the only alternative.

In this one has two main objects: 1, empty the distended bowel; 2, remove the cause of the obstruction.

Although the second of these requisites is the most desirable always, still the patient's condition will seldom allow it and, even so, would be useless unless the putrid contents of the intestines are removed. Hence in most cases, the engorged bowel is first dealt with by establishing under local anaesthesia an artificial anus or jejunostomy, leaving the search of the obstructing body till a later date.

A small incision is made through the linea alba below the umbilicus, or left rectus incision, the first presenting coil of the small bowel is withdrawn and a purse-string suture is passed, the gut is incised, and a small rubber tube inserted, which is fixed to the abdominal wall. Thus the bowel is emptied of its putrid contents. Vomiting ceases instantaneously, and

in cases of paralytic ileus normal bowel movements will be re-established in a day or so.

Morphia is almost always given for the relief of pain during the 24 hours following an operation. The cause of pain is due to gas in the intestines; or else from the handling and bruising of the tissues during the surgical interference. Some patients are very susceptible to morphia; and one hypodermic, after the narcotic effect has passed off, will act as an emetic for 12 to 24 hours. In these cases, of course, some substitute for morphia must be resorted to, as heroin, codein, etc.

In dilatation of the stomach there is a curious condition occasionally met with in surgical practice as an unexpected and unwelcome sequela of operation. It is characterized by a sudden onset, the vomiting of enormous quantities of fluid and severe general symptoms which usually terminate fatally in a few days. The stomach becomes enormously dilated, even sagging down into the pelvis, and the walls are more or less paralyzed, as peristalsis is rarely evident. The pathology of this condition is rather uncertain, but it is possibly due to a constriction of the third piece of the duodenum by the root of the mesentery through a downward drag of the intestines. The treatment consists in regular stomach lavage, and in some cases the abdominal decubitus has given relief; rectal alimentation being required, surgical treatment seems of no avail.

It is the nurse's duty to properly interpret these various forms of vomiting and to describe in her observations on the chart in an appropriate way the various characteristics of the vomiting. Thus and thus only will the competent nurse sound the danger signal if she is capable of understanding the meaning of post-operative vomiting.

Ignorance

(Everett Dean Martin in "The Need of a Liberal Education")

Once I thought that ignorance was an innocent thing, a sort of spiritual vacuum passively waiting to be filled with precious truths. Except in children ignorance is by no means an innocent thing. It is a very active element in human life. We must overcome strong resistances before we may begin to learn some things. We keep ourselves in ignorance because there are facts and truths whose existence we prefer not to admit. The man who strives to educate himself—and no one else can educate him—must win a certain victory over his own nature. He must learn to smile at his dear idols, analyze his every prejudice, scrap if necessary his fondest and most consoling belief, question his presuppositions, and take his chances with the truth. The greater the need of education, the stronger the resistance to it.

Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section,
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Midwifery in England

By MARY BEARD

(Continued from February)

The Village Nurse-Midwife

Miss A. M. Peterkin, General Superintendent of the Queen's Institute, writes as follows of the village nurse-midwife, and the comparative cost of her service and that of a fully trained Queen's Nurse.

As to whether a village nurse-midwife is the best woman for the work she is doing is, at the present time, a matter of opinion, but that is so chiefly because of the medical and surgical cases which fall to her and not on account of the midwifery part of her duties.* Personally, I think that the better trained, better educated and better class a nurse or midwife is, the better work she does whatever may be its locale, though I agree that the work done by our village nurse-midwives is wonderful.

When a district is sparsely populated and the area is already large, it would not be possible to obtain more work for a fully-trained nurse and, in that case, employing her would cost a great deal more than employing a village nurse-midwife. It is only when the population and area are such as to admit of a fully-trained nurse obtaining more work than a village nurse-midwife can undertake, that the cost works out about the same, taking into consideration the amount of work done. The difference between the cost of a fully-trained nurse and a village nurse-midwife is approximately from £40 to £50.

The County of East Sussex has been especially successful in assimilating a number of village nurse-midwives. The secret of their success would seem to lie in a remarkable co-ordination of health services, and in a particularly well organized and thorough system of supervision.

In East Sussex a complete co-ordination of public health nursing, including a midwifery service, has been put into effect to the mutual satisfaction of the Medical Officer of Health and of the administrative officer of the East Sussex branch of the Q.V.J.I. Each nurse carries all of the nursing functions of her district, a completely generalized service under careful supervision. These services include:

Health teaching in the schools
Tuberculosis nursing
Bedside care
Maternity and Child Welfare, which includes care at normal confinements.

It is astonishing what good results are obtained by village nurse-midwives. They come chiefly from the upper servant group, and from a background of training and social standing hardly ever found in the United States.

The work of one of the East Sussex village nurse-midwives seemed so intelligent and effective that it was interesting to learn more of her preparation for such a life. She had been a children's nurse, chief of a staff of three in a large private nursery, and had spent years in the same "county" family.

There are eighty village nurse-midwives, and only twenty fully trained nurses in the East Sussex Nursing Federation. The superintendent gives much time and care to the selection of the village nurse-midwife. When a village is getting ready through its local committee, to install such a worker, the superintendent advertises for a young woman to be trained for the position. From the applicants she selects the one best suited to the locality to be served.

*She cannot undertake such cases while a fully-trained Queen's nurse can.

The training is intensive and severe and is given at one of the Queen's centres.

All villages are visited by the supervisor of the district at least once in three months, and visits to the homes are made with the nurse or village nurse-midwife. The supervisor visits local schools in each village at least once a year. She goes regularly to the child welfare centres of which in one district there were eleven within twenty miles. The regular visits of the supervisors of these centres bring the supervisor into contact with the local nurses much more frequently than the quarterly routine would indicate.

An example of the practical working of the system was found in the following statement:

On finding a child with a "running ear" at a school examination the doctor followed the routine procedure and sent a report to the district supervisor and also to the village nurse-midwife. The child was to be watched for any increase in evidence of inflammation. The local village nurse-midwife knew nothing of the danger of mastoiditis, but was eager to be taught. When on her next visit the supervisor asked how the child was she found that the village nurse-midwife had proved an apt pupil, having succeeded in discovering the danger symptoms, persuading the family and getting the child to a hospital at some distance where an immediate operation saved its life—all this within forty-eight hours of the appearance of the symptoms.

Even though these instances of successful health work can be multiplied, the consensus of opinion seems to be that fully educated workers are better and that the use of automobiles might make it possible to combine two rural sections. This would provide enough work to fill the time of a nurse who could also practise midwifery.

Again it is brought home to one that the economic and social status of the midwife has much to do with her willingness to stay and work many consecutive years in these small country places—and indeed, in many cases, with making it possible for the right sort of woman to do so.

In great part owing to the village nurse-midwife the maternal death rate among more than 50,000 mothers of Queen's Institute patients throughout England was reduced to 1.8 per 1,000.

She costs $200 or $250 a year less than a nurse. She comes of a class not often found in the United States and is successful in so far as she conforms with the following conditions:

Careful selection from this class
Rigorous "training"
Scrupulous supervision.

The County Nursing Federation of East Sussex fulfils its most important function in selecting, training, placing and supervising nurses and village nurse-midwives. The Medical Officer of Health states that the county is now so well covered that there are only two vacancies in which nurses could be placed during the coming year.

Hertfordshire was the first county to complete an organization for efficient and economical midwifery, which in all essential particulars, is the same as East Sussex. As much as seven years ago Hertfordshire had a complete trained midwifery service and it is still the only county in England of which this is true. An interesting plan, in practice elsewhere also, was observed in Hertfordshire—namely, if a mother does not apply for care at confinement long enough before to admit of giving ante-natal care for three months, she is obliged to pay a double fee for delivery.

Public Health Administration of Midwifery in England

The National Health Insurance Act, passed in 1913, is contributory and compulsory. Workmen and their employers together pay seven-ninths of the whole, and the remaining two-ninths is paid from moneys provided by Parliament. The employer pays a sum equal to that contributed by the employed in the case of a man, and a little more than that in the case of a woman.

Maternity Benefit

Important to our study is the maternity benefit allowed under the Health Insurance Act. It amounts to a sum of 40s. per insured person, and if his wife herself is also employed, she may receive another 40s. In this case as much as 4 pounds or $20 may come into the family at the time of the confinement. These unsupervised cash payments are made either directly through an approved society or, if the beneficiary is not a member of an approved society, through an insurance committee established for that purpose. There is a tendency on the part of approved societies to add more benefits in the way of nursing, midwifery and so on, to those already to be obtained through the Health Insurance Act. It is stated that there is a present surplus in the hands of the approved societies of thirty million pounds.* Surveys are being undertaken in certain parts of the country to ascertain how many Queen's nurses would be needed in order to "cover" the area if nursing were added to the benefits under the Act. From the point of view of developing a sufficiently large group of supervised workers to make the Midwifery Act of England effective in all parts of the country, this tendency on the part of the approved societies opens a very interesting prospect.

The following financial statement was provided by Dame Janet Campbell of the Ministry of Health:

YEAR 1922-1923

Net expenditure of Local Authorities		**Gross expenditure**
Midwifery	£ 47,252	£ 59,860
Maternity Homes and Hospitals Infants' Hospitals	£200,788	£250,515

The grant paid by the Ministry of Health to Local Authorities amounts to half the net expenditure, i.e., £124,020.

Grants paid to voluntary agencies in the year 1923-1924 in respect of expenditure for year 1922-1923

Midwifery		£ 31,017
The amount is made up as follows:		
To County Nursing Associations	£ 18,339	
To County Councils for distribution to unaffiliated District Nursing Associations	£ 1,164	
To direct grants to unaffiliated District Nursing Associations and other Institutions undertaking District Midwifery in large urban areas	£ 11,514	
Maternity Homes and Hospitals	£ 70,226	Total £101,243

Maternity Benefit	**Men**	**Women**	
Payments through:	£	£	
Approved Societies	1,121,000	175,000 146,000	
Navy and Army Insurance Fund	43,000	.....	
Deposit Contributors Fund	13,000	2,000	
	£1,177,000	£323,000	
			£1,500,000
Grants paid to Local Authorities			124,020
Grants paid to Voluntary Agencies			101,243
Total Government Expenditure for the Year 1922-1923			£1,725,263

It shows that the sum of £1,725,263 for the purpose of maternal care passed through the hands of the Ministry of Health in the year 1922-23. One can not quite say it was expended by the Ministry of Health, since the unsupervised cash payments under maternity benefits were of course partly made up of money which came from the workmen. Since the taxes of the people

*1925.

provided the money from which local grants are made, this is also true of the local grants matched by an equal sum from the Ministry of Health.

One is impressed by the wisdom of the so-called "fifty-fifty" plan adopted by the Ministry of Health and associated with the name of Sir Arthur Newsholme. By this plan the health agency, whether public or private in character, may receive a grant from the Ministry of Health equal to the budget presented, provided the budget of the plans for its expenditure is approved by the Ministry. Many rulings have been made by the Ministry of Health since this Act was passed, and all these rulings are permissive and suggestive in character, For example, the Medical Officer of Health may

Subsidize the salary of a midwife
Pay the full salary of a midwife
Open a maternity home
Pay for the upkeep of certain wards for maternal care in a Country Hospital.

If these things are done by the local authorities and approved by the Ministry of Health, the local authority will in return receive half the amount of the proposed budget from the ministry. The effect of this ruling has undoubtedly been to stimulate desirable health development, and has tended to standardize the work for mothers and children throughout the country.

The Midwives Act of England was passed because of the conviction that a large number of women were economically unable to have proper care at the time of confinement. All the evidence seems to the writer to be of a nature to endorse the wisdom which made the Midwives Bill a law in 1902; but it is disappointing to find so little* statistical evidence of decreasing maternal mortality.

The proportion of maternal deaths per 1,000 live births was 4.6 in 1860 and 5.7 in 1892, taking, however, the five-yearly intervals, which give a more accurate idea than single years, the quinquennium from 1891 to 1896 showed 5.49, after which there was a marked fall up to 1906-1910, when the rate came down to 3.74, after this a rise to 3.88 occurred in 1916-1920. The rates available for the last five years are:

1918	3.55
1919	4.12
1920	4.12
1921	3.91
1922	3.8

Still more disappointing is the absence of any decided diminution in the septic rate. . . . The reason for the failure to diminish the child-bed sepsis rate is still to find.**

The more frequently comparisons of statistics arise, the more profoundly have I come to distrust all such comparisons.

However, the facts connected with the birth of children, wherever studied, (unless there is an income large enough to assure the attendance of a skilful obstetrician), admit of no other conclusion but the necessity of a safe attendant, other than the busy general practitioner, for normal childbirth in any community which has undertaken to provide a reasonable public health programme. Such attendants may be called accoucheuses, midwives, obstetrical assistants or maternity nurses, the only essential being that they should possess the added education which would make them equal to attending normal confinements; but whatever they may be called, the need for them seems to be a matter which cannot be questioned. Moreover, the need is not a temporary one, but has always existed and will always do so.

The ideal toward which England is working is that all women shall be supervised during pregnancy and provided with an attendant capable of conducting normal delivery and of being trusted to observe surgical asepsis throughout confinement, to send for a doctor when the need arises and to give proper care during the post-partum period.

*From a letter from Dr. John S. Fairbairn: "As I told you when you sent me your preliminary report, I think you exaggerate a little the failure to reduce the maternal mortality, because the last 25 years have seen quite a recognizable drop. I will not say it is anything like what it should be or that it is in any way comparable to the drop in the general or infantile mortality rate but the figures at the end of the last century, and those of the last few years show a distinct improvement. The 1919 and 1920 figures, in which the mortality just exceeded 4 per 1,000, were undoubtedly exceptional, and for some years before and the year since, it has been about 3.8. At the end of the last century it was round about 4 and occasionally in the neighborhood of 5,and even .1 per 1,000 means a saving of 750 maternal lives on our annual birth rate."

**Gynecology with Obstetrics (Chapter 34), John S. Fairbairn, M.A., etc.

Making Confinement Safe

To make confinement safe, a doctor who possesses special knowledge of obstetrics and a woman who possesses special knowledge of normal delivery are necessary. The midwife and doctor should not in any sense be rivals. The supervision of pregnancy should mean examination by a doctor and supervision by a midwife who may report to the doctor. In order to secure this relation between doctor and patient, there should be a retaining fee for the doctor and a regulated payment for the midwife. The case will then be conducted under the direction of the doctor, who will not choose to be present unless something out of the normal occurs.

Many difficulties in the situation in regard to maternal care in England would disappear if the social and economic status of the midwife could be made as suitable to her position as that of the practising doctor is to his—this Denmark has accomplished after an experience of nearly 200 years more than England has yet had.

The Scottish Report says:

> In virtue of the long and costly training and the late age at which professional activity begins, the medical practitioner is an expensive social instrument which it is no economy to use for work that may be performed more simply. There is social confusion when doctor and midwife have to be treated as competitors; they should be considered not as rivals to each other but as complementary.*

When, as in Denmark, normal confinement comes universally under the charge of such an attendant, social confusion disappears, and the skilled obstetrician undertakes only intricate cases of abnormal labour with a midwife as his valued assistant. Danish doctors recognize that midwifery, in this sense, is as much a nursing function as giving a temperature bath to a typhoid patient or assisting with a surgical dressing. It goes without saying that one essential for the mother in child-birth is perfect calm in her attendants—a calm sometimes difficult to the busy practitioner, who may be obliged to come in and out many times during the course of labour. Nursing care of the mother is necessary to ensure her recovery from the dangers of childbirth. In families where there is neither nurse nor midwife this constitutes a serious difficulty.

The Scottish Report further says:

> The second difficulty with which the doctor must deal in domestic practice, whether he is himself primarily responsible for the case or is called at the instance of a midwife, is due to the fact that the suffering of the woman leads to a demand for relief, and the doctor is believed to have in forceps the means to end the labour. It has been represented to us that doctors yield to this demand too early and too often, and grossly deleterious results follow.
>
> Thus to the development of antenatal care and to the due co-operation of midwife and doctor we may reasonably look for the reduction of the number of cases in which forceps may be used injudiciously.*

In Conclusion

The English statistics fail to establish very marked improvement in the past twenty years, but it is possible that the figures do not show all the facts; the death rate is capable of being reduced, and ante-natal care is the most hopeful means of obtaining this end. In general, the chief causes of death are:

Sepsis
Hemorrhage and accidents of labour.

Even though there is so slight a lowering of the rate of maternal mortality, midwives and doctors are both necessary to reduce preventable deaths and to prevent unnecessary and prolonged illness with its accompanying economic loss. If doctors and midwives undertook a greatly extended and better co-ordinated ante-natal service substantial results could be looked for. To this end and for other reasons, better education is needed both for medical students and for midwives. With better education of the midwife a better social position and earning capacity are inevitable. When the economic and social status of the midwife is raised, her employment by all doctors to assist in maternity cases will naturally ensue. There are more than 35,000 certified midwives in England who do not intend to practise and only 16,000 who do. This large number of non-practising midwives consists chiefly of nurses who consider

*Report of the Scottish Departmental Committee on Puerperal Morbidity and Mortality, Edinburgh, 1924.

it part of their education to take the midwives' course. The number ought to be very much reduced, as it adds greatly to the difficulties of teachers of midwifery and serves no useful end, other than that attained in American and Canadian hospitals by teaching maternity nursing within the period of the three years' training as nurses.

In certain parts of rural England a very efficient plan has been established by which a safe attendant in child-bearing seems to be assured for every woman in the county. When public opinion has reached the point where every woman in these countries sends, as a matter of course, for this safe attendant, and when co-operation between doctor and midwife is better, the maternal death rate—which is already low in these localities—will probably drop to the irreducible minimum. The characteristic features of this successful plan are

Co-ordination of all community health service under the County Council, with active co-operation of the Queen's Institute (County Nursing Federation).

The employment of two grades of nurses who are also midwives (20 fully-trained nurses who act as supervisors and 80 village nurse-midwives).

Finally, even though the excellence of the midwife's technical training is unquestioned and her skill in delivery is great, unless she becomes an ethical factor in community life and maintains the traditions of service established by doctors and nurses, she is bound in any country to be a source of evil rather than good.

Midwifery Legislation and Practice in Canada

By ANNE SLATTERY, Montreal

There is very little to be said on the first part of this subject as seven out of nine provinces have no legislation nor any official recognition of midwives. The only two where there is official recognition are the provinces of Nova Scotia and Quebec.

The following are the clauses of the Medical Act of Nova Scotia:

40 (1) Nothing in this Chapter shall prevent any competent female from practising in this province, except in the City of Halifax.

(2) In the City of Halifax no female shall practise midwifery unless she first fulfils such conditions as the board by regulation or by law appoints, and satisfies the examiners appointed by the board for that purpose of her competency, and obtains from the board a diploma or certificate of qualification, and has registered as hereinbefore provided.

(3) In lieu of an examination, the board may accept from any such midwife practising or proposing to practise in the City of Halifax a diploma or certificate from a recognized lying-in hospital which provides a regular course of instruction, and requires an examination equivalent to that required by the board.

12 (h) Cause every midwife in the City of Halifax to enter in a register of the board to be kept by the Registrar, and to be called the Midwives Register, her name, place of residence and age, as well as her license or certificate, or the nature of her qualifications or authority to practise as a midwife.

At the present time there is record of only one midwife practising in Halifax under these regulations.

In Quebec the law demands that midwives be licensed by the College of Physicians and Surgeons of Quebec under the following regulations:

Laws and Regulations

Chapter XVIII.

1. The Medical Bureau has organized a committee of three members for the midwives examination. This examination takes place the day before the yearly meeting of the Medical Bureau.

2. Each person who desires to present herself before the Provincial Bureau (medical) to be examined, and to obtain the permission (or to be allowed) to practise the obstetrical act in this province, must produce ten days in advance:

(1) A certificate of attendance, at least, at fifty courses, given by a professor of one of the three universities, also attached to a maternity hospital.

(2) A certificate of regular attendance, during six months, in a maternity hospital affiliated to one of the universities.

(3) A certificate attesting her attendance at twenty-four confinements at least.

(4) A certificate proving her high morality and her knowledge of reading and writing.

3. Each person, who passes, with success, her examination and observes all the rules and regulations of the Medical College, is admitted as a certified midwife of the Province of Quebec. This certificate gives her only the right or privilege to confine any woman. She has not the privilge to practise medicine. If the confinement was not normal or presenting difficulties necessitating medical or surgical care, the midwife should call a doctor or she could be fined as practising illegally medicine (4928-4971 S.R.).

4. A fee of twenty dollars ($20) for examination and registration of midwives should be made to the Registrar, at least ten days preceding the date of the examination.

At present about twenty midwives are practising in Montreal under these regulations. A few hold foreign diplomas.

Midwifery practise in Canada, either trained or untrained work, is naturally a subject for much interest to us. Although there is very little definite information available, and apparently little work being carried on by a trained personnel, yet we all know that in Canada the untrained midwife does function. This is largely because of conditions that prevail in the districts where it is difficult or impossible to secure medical attention because of the distance and also the expense involved. In our country of great spaces we always have to consider the position of the scattered or isolated settlers in the rural districts. Here the custom is very often to have the confinement attended by some untrained woman, generally a neighbour who attends to all the confinement cases in that locality.

With a view to finding cut the present extent of this practice, which a generation or two ago was quite prevalent everywhere in this country except in the towns or large settlements, enquiries were made of the various health departments in the different provinces as to what number of births they had recorded annually without medical attention. Only a few of the provinces were able to give any information of this kind. Nova Scotia, in 1924, had 18% of recorded births without any medical attention. New Brunswick, in 1925, had 25%. In 1924, Saskatchewan had 31% of registered births without medical attention.

It is probable that these births were attended by an untrained person who would thus function as a midwife.

It is interesting to note the midwifery cases that are attended by trained nurses. The nurses of the Canadian Red Cross outposts have cared for confinement cases as a part of their work. In the last annual report of the Society the number of confinement cases attended without a doctor in attendance is given as 114. In Alberta maternity cases in the remote districts have been attended by the Provincial Public Health Nurses who are engaged in District Nursing. These nurses have had special midwifery training as they were mostly trained in England, and hold their C.M.B. certificates.

(Concluded on Page 157)

Department of Student Nurses

Convener, Miss M. HERSEY, Royal Victoria Hospital, Montreal.

Nursing Education from a Student's Viewpoint

By MAUDE PORTEOUS, Winnipeg General Hospital, Class 1927.

In one of his Essay's Emerson has written that "nature has admirably fitted a man to his surroundings by making these the fruit of his character. "Thus", he goes on to say, "soldiers take to the saddle, priests to the cloister, sailors to the sea"—and had he lived in these enlightened days he would have included women in his philosophy and doubtless have added, "brilliance takes to the arts, while nurses take to the 'Wards'." For it has probably been the experience of every student nurse that certain promptings, certain natural proclivities first induced her to embark upon the arduous profession of nursing, and make it her vocation work. Very few weeks of the probationary period are sufficient to demonstrate whether enthusiasm is of the type that will endure, or whether it has been merely a temporary fascination for a life not without its romantic appeal. For it seems to be a fact that the probationer is encouraged in a confusing multiplicity of new and unfamiliar duties only by her enthusiasm for the work she has undertaken, and as this begins to be unduly overbalanced by domestic duties which interfere with progress in what has been eagerly anticipated as the real practical work of nursing, some stimulus to continued enthusiasm seems to be required. Domestic duties, it is said, are fewer than they used to be, while the educational side of a nurse's training is becoming more emphasized. Many hospitals have already installed a vastly increased number of ward maids while many improvements and labour-saving devices have been introduced. On the other hand, it must be recognized that Ward Hygiene must always form an important part of a nurse's education. To make time for study by transferring all these duties to ward maids would be expensive and undesirable. The change, however gradual, has come about, and the "handy women" of years ago are becoming scientific but efficient nurses. With the knowledge of why and wherefore a greater degree of efficiency is obtained; thus a demand for nursing instruction and increased time for study.

Since Florence Nightingale elevated nursing to the dignity of an art leading to a profession; one demanding in its higher branches all that a woman can possess of culture, intellect and altruism, many have laboured in face of countless obstacles to give it the dignity of the professional status which it is rapidly attaining. The Schools of Nursing are still merged in the hospitals, and the public lack interest in a development which is profoundly their concern. The nurse as a finished product of scientific training must be a teacher of health and hygiene, an instructor by precept and practice, a missioner by instinct and example; an educator in the fullest sense, physically, mentally and spiritually—imparting that spirit of human happiness which comes of a knowledge and understanding of the basic principles of the health and hygiene of life, all of which should be kept in view when planning her education.

If there is a glamour and an enthusiasm to a student nurse there is also a very definite desire for service

(Read before the annual meeting of the Manitoba Graduate Nurses Asscoiation, January 28th, 1927.)

and a life work. And who shall say that they have not moments of disillusionment; of shock, fatigue, and of a sense of sacrifice, a sense of the futility of theoretical study while overcome with physical fatigue often bordering on exhaustion? These are passing phases, no worse perhaps than the momentary gloom which steals on the spirits of men and women of other professions and callings.

As they pass from the period of probation to the rank of juniors they are urged by new enthusiasm in the proper attitude towards the patients, the first real glimpse of the work that was their early inspiration, the first proud thrill of responsibility—vastly exaggerated in the light of their later training but very real and very essential nevertheless. Here they are faced with longer hours and still much weariness of the flesh. Here is the first settled conviction that they could immensely improve the whole curriculum, if only those in authority, those head officials, would profit by their enlightenment!

In the intermediate year they are still in the process of being inured to shock and nervous strain. It is during this stage that they seem to develop a tendency either to become entirely engrossed in their work to the neglect of all recreation and amusement, or to lose vital interest: to accept all the social diversion they can find time for and to scrape through their studies and their practical training. All know the danger point, and bless the day when their equilibrium adjusts itself and they realize the happy medium.

As seniors they are seized afresh with a full year of responsibility and awakening of a consciousness of the balance and purpose of their training, a fuller grasp of their ability to direct and a renewed pride in the care of the patients now under their care. They regret that their earlier training left them too little time for the things which would have made for more complete knowledge, they re-dedicate themselves to the real work of nursing.

Special courses reveal to them the field of specialization open to a fully trained nurse, and graduation must surely convince them that the "greatness of their high hopes and ambitions will run round their incompleteness and round all the turbulent restlessness of their hurried training, the rest and satisfaction of bringing relief here and there to human suffering."

BOOK REVIEWS

A Vade Mecum — for nurses and social workers: by Rvd. Edward F. Garesche, S.J., The Bruce Publishing Company, Milwaukee, Wisconsin.

The author has evidently wished to meet the spiritual need of nurses and social workers in the discharge of their arduous duties. The form is a very compact manual of ethics, reflections, reminders, prayers and devotions in time of need. This book, as its name implies, should prove to be the constant companion of charitable workers in their spiritual and corporal ministrations, it should be also an inspiration in the difficult problems dealt with daily.

Sodalities for Nurses, by Rvd. Edward F. Garesche, S.J., The Bruce Publishing Company, Milwaukee, Wisconsin.

This book covers its subject exceedingly well. The need of establishing Sodalities for nurses is brought to the attention of superintendents of Catholic training schools in a very clear and concise way, while the methods of conducting their activities, and results attained, are given in a more elaborate form.

This book should do much towards the promotion of Sodalities amongst Catholic nurses, thus binding the ties of cherished memories to their Alma Mater, while continuing in a systematized way the charitable and spiritual work started under her sheltering arms.

ALICE LAPORTE, Reg.N.

Our Canadian Mosaic, by Kate A. Foster.

A vivid picture of Canada's newcomers; their contribution to the national life, their problems, our responsibility and opportunity, are cleverly sketched in this illuminating survey, which is most timely in its application to the whole problem of immigration. Price, 75 cents. Publications Department, Dominion Council, Y.W.C.A., 12 Dundonald Street, Toronto 5, Ont.

News Notes

ALBERTA

CALGARY

Miss H. Ash, superintendent of the Victorian Order of Nurses, has been giving a series of addresses on public health and home nursing over CFAC, The Herald broadcasting station, Calgary.

Members of the Calgary Association of Graduate Nurses will be pleased to learn that Miss MacDermott is now able to leave the hospital and is convalescing satisfactorily.

BRITISH COLUMBIA

A general meeting of the Graduate Nurses Association of British Columbia was held on Saturday, January 29th, at eight p.m. in the Auditorium of the Vancouver General Hospital, the second vice-president, Miss Jessie MacKenzie, R.N., in the chair.

Meetings of the three standing committees—Public Health Nursing, Private Duty Nursing and Nursing Education—as well as two meetings of the executive council, had been held earlier in the day, one in the morning and one just prior to the general meeting in the evening.

The members had much pleasure in listening to a most able address on current events, with special reference to China and the situation there, given by Miss Mary Bollert, Dean of Women, University of British Columbia, who spoke in her usual interesting manner.

Certain changes in the by-laws, which had been presented to each member to vote upon by ballot, were passed. These included methods of voting, nominations and the inclusion in the nominations for a two-year service of conveners of the committees on Public Health Nursing, Private Duty Nursing and Nursing Education, making them members in this way of the executive council, which is limited to twelve members.

The following resolution was sent in to the general meeting from the council and was unanimously passed:

"Whereas it has been brought to the notice of the Graduate Nurses Association of British Columbia that one of its members, namely, Miss Jessie F. Mackenzie, R.N., who for the past fourteen years has been actively engaged as superintendent of nurses at the Royal Jubilee Hospital, Victoria, B.C., has been summarily dismissed from this position; and

"Whereas this action has been taken by the board of directors of the hospital, without due notice and without giving any reason therefore;

"Now, therefore, be it resolved that we, the members of the B.C.G.N.A., desire to go on record as being astounded and indignant that a board of directors in whom the public have vested such authority and responsibility should adopt such a method in dealing with the superintendent of nurses after entrusting her for fourteen years with the care of their patients and the responsibility of their training school, and we do hereby make a formal protest against the lack of justice shown in this action by the board of directors of the Royal Jubilee Hospital, Victoria."

It was moved, seconded and unanimously carried that a copy of this resolution be sent to the secretary of the said board, to the two Victoria daily papers and to the British Columbia Hospitals Association asking that it be read at their next convention.

The council were entertained at lunch by Miss Ellis, R.N., of the Vancouver General Hospital, and refreshments were served after the evening meeting by the Alumnae Association and staff of the Vancouver General Hospital.

Musical selections were given during the evening by Miss Geary, R.N., accompanied by Miss Helen Bennett, R.N., both of the staff of the Vancouver General Hospital.

VANCOUVER

General Hospital

The annual meeting of the Alumnae Association was held at the Nurses' Residence on Tuesday, February 1st, when the officers were elected for the coming year. Mrs. Grainger (Freda Martin, 1921) was elected president; Miss Harvie, secretary; Miss Geary, treasurer. At the close of the business meeting the graduating class was entertained, the entertainment taking the form of a masquerade party. A very enjoyable time was spent.

Miss Muriel Hobden, 1924, has returned to the city from Creston.

Miss Ann Hedley, 1924, has returned from an extended trip to England.

The Misses Jean McVicar, 1923, Cassie McKinnon, 1923, and Norah Senkler, 1926, attended the ski jumping carnivals at Revelstoke and Banff.

Miss F. Newman, 1924, and Miss Isobel Reid, 1923, have returned from Ocean Falls. Miss Newman joined the staff of the new Isolation Department of the Vancouver General Hospital, and Miss Reid is doing special duty.

Miss Mary Pearcey, 1917, has left for Mexico, where her marriage to Mr. MacLachlan will take place.

MANITOBA

The thirteenth annual meeting of the Manitoba Association of Graduate Nurses was held in the Parliament Buildings, Winnipeg, on Thursday and Friday, January 27th and 28th, 1927. Afternoon and evening sessions were held each day. Preceding the afternoon session on January 27th, sessions of the three sections—Nursing Education, Public Health and Private Duty—were held concurrently. The opening and business session on Thursday was well attended and from reports presented one judged that the association was making progress and increasing its membership. Speakers who addressed the various sessions were: Miss Laura Logan, Dean, Illinois Training School of Nursing, Chicago; Dr. D. A. Stewart, Ninette Sanatorium, on Heliotherapy; Dr. C. M. Clare, of Winnipeg, an illustrated lecture on Strabismus; Mr. D. B. McRae, of the Manitoba Free Press staff, on the recent Imperial Conference in London; Miss Irene McGuire, on Private Duty Nursing, and Miss Maude Porteous, student nurse, Winnipeg General Hospital, on Nursing Education from a Student's Point of View. Miss Laura Logan was the guest of the association during the annual meeting and gave several most inspiring talks on various subjects relative to nurses and nursing. The closing session followed a dinner at the Fort Garry Hotel, when in addition to music and several addresses, the members were given the opportunity to meet Miss Logan.

BRANDON

Dr. and Mrs. Pierce entertained the members of the Graduate Nurses Association and friends at a delightful travelogue illustrating a motor trip to the Pacific coast and through Yellowstone Park.

Miss Marjorie Trotter (B.G.H., 1924) has left for Santa Rosa, California, where she has accepted a position.

Representatives from Brandon to the annual meeting of the Manitoba Association of Graduate Nurses at Winnipeg during the last week of January included Misses C. Macleod, A. Francis, R. Dickie, M. Skinner, and N. Shaughnessy.

The game of Badminton has proved to be a popular method of recreation amongst members of the nursing profession this winter. Several interesting games and tournaments are being arranged.

The monthly meeting of the Nurses Association was held at the Mental Hospital on February 1st, when Dr. Spiers gave a most comprehensive and interesting lecture on Preventive Dentistry, illustrated by slides. Refreshments were served at the close of the meeting.

Miss Eva Pitt, formerly of the Mental Hospital staff, spent a few days in the city when en route to Saskatchewan, where she is about to undertake duty in a Red Cross hospital.

NEW BRUNSWICK

MONCTON

On December 16th, 1926, at New Glasgow, N.S., Miss Nellie Brydges passed away following a painful illness of three weeks, due to septicemia. Miss Brydges, who was a graduate (1922) of the Moncton Hospital and a member of the New Brunswick Registered Nurses Association, was an excellent nurse, and was held in the highest esteem by all those with whom she came in contact. She will be greatly missed both professionally and socially by her many friends.

SAINT JOHN

The St. John Chapter of the New Brunswick Association of Registered Nurses held a very successful bridge in the Pythian Castle on Tuesday evening, January 11th. The convener, Miss Lula Gregory, was assisted by Miss Ella McGaffigan. The guests were received by Miss Mitchell, president, and Miss Coleman, vice-president. The first prizes were won by Mrs. Ralph Robertson and Dr. H. Clark, second prizes by Mrs. George Flemming and Dr. C. M. Kelly. Refreshments were served at the close of a very pleasant evening.

Miss Elsie Shaw and Miss Mabel Jones have returned to Boston to resume their duties.

Miss Lyla Belding, anaesthetist, General Public Hospital, who was operated on recently, has returned to her home in Hampton. Her friends will be glad to learn of her speedy recovery.

Miss Louise Peters, of the General Public Hospital staff, is at home convalescing after a recent operation. Miss Frances Day is relieving for Miss Peters.

NOVA SCOTIA

HALIFAX

The graduation exercises of the Halifax Infirmary Training School for Nurses were held in St. Mary's Hall on January 27th, the Rev. Father McManus presiding. The following graduates received the diploma of the school:—Misses Helen Agnes Lahey, Adora Salterio, Marie Agatha Healy, Helen Kathleen Mont, and Marie Surette. The valedictory address was read by Miss Healy and the address to the graduates was given by Dr. G. H. Murphy. The gold medal for highest aggregate, donated by the Rev. Father McManus, was awarded to Miss Salterio; five dollars in gold, donated by the Infirmary staff, to Miss Surette for excellence in practical work. The special prize for highest marks obtained in the examination for provincial registration was won by Miss Hen-

derson. In the evening the graduates were guests at a dance given by the Ladies' Auxiliary of the Infirmary.

Miss Mary E. Hazard was a recent visitor at the Dalhousie Public Health Clinic, en route to Bermuda. Miss Hazard was formerly a member of the staff of the Massachusetts-Halifax Health Commission.

Mrs. Celeste Macdonnell, school nurse, of Sydney, N.S., visited friends in Halifax during the Christmas vacation.

Miss Mary Hayden, president, local branch N.S.R.N.A., has returned to her duties on the M.H.H.C. staff after a very enjoyable vacation, spent in New York and other American cities.

Friends of Miss L. McInnis will regret to learn that she is at present a patient in the Halifax Infirmary.

Miss Veronica White, public health nurse, Campbellton, N.B., was a recent visitor to the city.

Miss Marjorie Trefry, Dalhousie Public Health Clinic staff, has resumed her duties after an illness of six weeks.

Miss Martha Campbell, county tuberculosis nurse, recently spent three days in Halifax, doing district work with the nurses of the M.H.H.C.

The nurses of the Victorian Order in Halifax are deeply indebted to Lieut.-Governor Tory for the gift of a sedan car for use in their work around the city. This generous gift fills a long-felt want and is generally appreciated.

The regular executive meeting of the N.S.R.N.A. was held on January 28th, the president, Miss Campbell, presiding.

ONTARIO

R.N.A.O. District No. 4

The annual meeting of the Registered Nurses Association of Ontario, District No. 4, took place on Saturday afternoon and evening, January 22nd, at the Ontario Hospital, Hamilton.

Nearly 100 nurses left by special buses at 2.15 p.m. and on arriving at the hospital were conducted to the Amusement Hall. After the singing of "O Canada", Dr. English, superintendent of the hospital, took charge of the afternoon session. His talk on Mental Diseases was most interesting and instructive. He touched on several types of mental disorders, and with the assistance of members of his staff held a clinic to illustrate the different groups. He also spoke of the value of vocational work by patients and a beautiful display of articles was on exhibition.

At 4.30 p.m. the nurses were personally conducted by Dr. English and his staff through the wards and were shown several methods of treatment used for nervous diseases.

Committee meetings were held for an hour, and at 6 o'clock the nurses were the guests of the Ontario Hospital at a most delicious supper. A very enjoyable social hour was spent and the singing of several solos by Mr. S. Patterson was appreciated by all. A hearty vote of thanks was extended to Dr. English and his staff by Miss Rayside for their kindness and hospitality.

At 7 o'clock all adjourned to the Amusement Hall where the annual meeting took place. Miss Ella Buckbee, chairman, conducted the meeting. Splendid reports, showing a strong and hearty co-operation in all work undertaken, were given by Miss Eva Moran, secretary-treasurer; Miss McIntosh, convener of Finance Committee, and Miss Sahnie, convener of Membership Committee.

The officers of the association were all re-elected, taking for the District No. 4 slogan, "Co-operation." All are looking forward to a successful year.

Several nurses are taking advantage of a university extension course of lectures in public health. This is the first course of its kind arranged outside of Toronto.

When the business meeting was concluded, Mrs. Sydney Dunn gave a very enjoyable and helpful talk on The Art of Reading Aloud and What to Read. Mrs. Dunn in a very charming manner gave selections from Bernard Trotter, William Makepeace Thackeray, and Robert Browning. Miss Holt moved a vote of appreciation and thanks to Mrs. Dunn.

The meeting closed with the singing of God Save the King.

BRANTFORD

General Hospital

The regular meeting of the Alumnae Association of the Brantford General Hospital was held on Tuesday evening, February 1st, at 8.30 p.m. The chief business item was the decision to donate $100.00 towards the equipment of a formulae room in connection with the Children's Wing. A very interesting and instructive lecture was given by Dr. E. R. Secord on Brain Surgery, which was appreciated by all. After refreshments had been served the meeting adjourned.

KINGSTON

General Hospital

The regular monthly meeting of the Alumnae Association of the Kingston General Hospital was held at the Nurses' Home on February 1st. Arrangements were made for Violet Day to be held on April 16th. At the close of the business meeting tea was served and a social half-hour spent.

The Misses Ada Amey, Adelaide Francis and Bella Gates, graduates of 1926, have

accepted positions at the Millard Fillmore Hospital, Buffalo, N.Y.

Miss Ruth Nash, 1926, and Miss Abbie Judson, 1922, have accepted positions at Lakeside Hospital, Cleveland, O.

NORTH BAY

The first annual meeting of District No. 9, R.N.A.O., was held recently. A banquet was given at the Pacific Hotel to the twenty-seven visiting nurses present. A very interesting paper on public health was given by Miss Kennedy (a public health nurse of Sturgeon Falls) and Mrs. L. O. Tremblay rendered a pleasing solo. The dinner was followed by a business meeting in the Nurses' Residence, Queen Victoria Memorial Hospital. The meeting was presided over by Miss Quinlan, of Q.V.M. Hospital, in the absence of Miss Riordan. Miss Harvey, dietitian, Q.V.M.H., gave a very interesting paper on diabetic diet. Lunch was served by the Alumnae Association. In the evening Dr. George Smith, of North Bay, gave an interesting lecture on Bacteriology, which was followed by the election of officers for the ensuing year. At the close of the meeting a dance was given by the school staff, which was a pleasant finale to a successful day. The following officers were elected: President, Miss Rogers, supt. Q.V.M.H.; vice-president, Miss Kennedy, Sturgeon Falls; secretary-treasurer, Miss McLaren, North Bay. The next meeting of the chapter will be held at Sudbury in June: date to be decided later.

Miss N. Keaye, a recent graduate of the hospital, has accepted a position as night superintendent, Q.V.M. Hospital.

ORILLIA

The graduation exercises of the class of 1926 of the Soldiers' Memorial Hospital took place on October 26th, the names of the new graduates being: The Misses Margaret Payne, Cora Buie, Florence Hillier, Edith Luck, Florence Graham, Elizabeth Mitchell, Mary McLelland and Edna Henry, who were the recipients of many beautiful flowers and useful gifts. The prize for neatness, donated by Mrs. Hamilton, was presented to Miss McLelland, and Miss Buie received the prize for operating room technique, donated and presented by Dr. Powell, of Toronto.

The official opening of the new nurses' residence took place on November 18th, 1926.

Miss Reid and Miss McDonald are doing private duty nursing in Brooklyn, N.Y.

Misses Hellier, Graham and Mitchell, 1926, have accepted positions on the staff of the M.F. Hospital, Gravenhurst, Ont.

Miss S. I. Duddenhoffer is now able to resume her work after a year's indisposition following pneumonia.

Miss L. Barry is recuperating after an operation at Victoria Hospital, Barrie, Ont.

Miss M. Goss is attending the public health nursing course at the University of Toronto.

PORT ARTHUR AND FORT WILLIAM

The monthly meeting of District No. 10, R.N.A.O., was held at the Nurses' Residence, McKellar Hospital, Fort William, on January 12th. At the close of the business meeting Dr. H. J. Ferrier, radiologist, gave a very instructive and interesting address. Refreshments were served by members of the hospital staff.

Miss M. Stowe, assistant superintendent, General Hospital, Port Arthur, leaves shortly for Kerrobert, Sask., having accepted the position of superintendent in the hospital there.

Nursing Sister J. Norton, of Port Arthur General Hospital, is taking a post-graduate course in operating room work at the Montreal General Hospital.

Miss Mary Pearson has accepted a position on the staff of the McKellar Hospital, Fort William, as supervisor of the surgical wards.

SARNIA

The graduation exercises of the Sarnia General Hospital were held in the auditorium of the Technical School on the evening of October 26th, when the following nurses received their diplomas: Misses M. Wood, M. Rawlings, K. Ratley, M. Jennings, V. Johnston.

On December 7th, 1926, a very successful bridge party was given by the Alumnae Association of the Sarnia General Hospital at St. Andrew's Hall. At the December meeting of the association it was voted that the sum of $50.00 be given to the Christmas Cheer Fund.

Miss Mary Fisher has accepted the position of school nurse in the Sarnia public schools, superseding Miss Menzie, who has accepted a similar position in the public schools at Kitchener.

The death at Parkhill on January 10th, 1927, of Miss Christine McKillop, a graduate of the Sarnia General Hospital, caused the deepest sorrow to her many friends.

TORONTO

General Hospital

Miss Marjorie Gall and Miss Eudora Watson, 1923, who have been at the Red Cross Hospital at Hornepayne, Ont., have moved to the new hospital at Bancroft, Ont.

Miss Helen Colling, 1926, has recently joined the staff of the hospital as assistant head nurse in the Emergency Department.

Miss Irene Slater, 1924, is taking a post-graduate course in operating room technique at the Toronto General Hospital.

A dinner in honour of the graduating class is being planned by the Alumnae Association to take place at the King Edward Hotel in March.

Miss Anne Wright has been appointed superintendent of the General and Marine Hospital, St. Catharines, Ont.

Miss Katherine Elliot (1924), who has been in charge of Ward "B," T.G.H., has left to spend a two months' vacation in Florida.

Hospital for Sick Children

Miss Dorothy Fisher, 1926, has accepted the position of supervisor at the Children's Department, House of Mercy Hospital, Pittsfield, Mass.

Miss Harriet T. Meiklejohn, for several years superintendent of the General and Marine Hospital, St. Catharines, Ontario, is now in charge of the Women's College Hospital, Toronto.

QUEBEC

MONTREAL

General Hospital

Miss M. G. Martin, 1921, recently joined the staff at the Laurentian Sanatorium, St. Agathe.

Misses Catherine Small and Marion Miller, 1927, have taken charge of a semi-private ward lately opened at the Montreal General Hospital.

Miss A. M. Cooper is carrying on a very successful tea-room named Lionden at 25 East 39th Street, in New York City. Miss Cooper will be glad to see any Canadian nurses who visit there.

Miss Alice LeGallais, 1924, has accepted a position as night superintendent, Albany General Hospital, Albany, N.Y.

Miss Isabel McConnell, 1925, was appointed recently to a mission station in India by the Women's Foreign Missionary Society of the Presbyterian Church of Canada.

Misses Gertrude Labelle, 1925, and Grace French, 1926, have accepted positions on the staff of the Royal Edward Institute, Belmont Park, Montreal.

The sympathy of the members of the Alumnae is extended to Miss R. J. Muffat in the loss of her brother, and to Miss Lillian Tracy in the loss of her sister.

Miss Elizabeth Ross was successful in obtaining her Master of Arts degree from the Columbia University last June, and also drawing the Isabel Hampton Robb Fellowship. During the last six months Miss Ross has been reorganizing the Olean General Hospital, Olean, N.Y. Miss Ross makes a specialty of the reorganization of hospitals.

Miss Elsie Tulloch, 1919, who has been assistant superintendent of Jeffery Hale's Hospital, Quebec, for some time past is now in charge of the Fisher Memorial Hospital, Woodstock, N.S., following Miss Gertrude Jackson, 1912, who resigned to be married.

The usual large reception and dance, with nearly four hundred guests, was given during the holiday season at the Nurses' Residence of the Montreal General Hospital, Dorchester Street E., when the lady superintendent and members of the Training School were At Home. The guests were received by Miss S. E. Young and Miss F. E. Strumm. Two large adjoining class rooms were given over to dancing, and smaller reception rooms were used as sitting-out places. Supper was served in the recreation room.

Mr. and Mrs. Septimus Barrow (Mary Shaw, Montreal General Hospital), who were married early in February, have sailed for Europe, where they expect to spend several months. Prior to her marriage Mrs. Barrow was superintendent of nurses, Jeffery Hale's Hospital, Quebec, for several years.

The Western Hospital

Miss Margaret Tyrrell has taken charge of the operating room at the Children's Memorial Hospital, Montreal.

Miss Mary Reynolds, who is doing private duty nursing in New York City, spent the Christmas holidays in Montreal.

Miss Marguerite Johnston, for some time engaged in private duty nursing in New York City, has taken a position in a doctor's office.

Miss Florence Whimbey has resigned from her position as supervisor of the Outdoor Department of the Western Division, M.G.H., and is doing private duty nursing in Montreal.

Mrs. J. J. Pollock (Evelyn Davidson) has returned to Montreal, where she will reside permanently.

Miss Marjorie Macfarlane has accepted a position on the staff of the Royal Victoria Montreal Maternity Hospital.

Miss Marjorie Reyner is spending the winter in the south, visiting relatives residing in Cuba and the Isle of Pines.

Mrs. Grace Taggart has resumed private duty nursing in New York City after having spent some time in institutional work.

The members of the Alumnae desire to express their deep sympathy to Mrs. Norman Fletcher (Vivienne Robertson) on the loss of her infant daughter, and to Mrs. Ross Penoyer (Florence McNie) on the loss of her seven-months-old daughter.

C.A.M.N.S. Notes

QUEBEC

MONTREAL

The annual meeting of the Montreal Overseas Nurses Association was held at the Graduate Nurses' Club House on Bishop Street at 8.30 p.m., January 27th. The president, Miss Watling, was in the chair and her address reviewed the work of the year, which was chiefly social. In February a bridge was held in the Nurses' Residence of the Montreal General Hospital; in August there was a reception at the Royal Victoria Hospital for Dame Maud McCarthy. The association was well represented at the unveiling of the memorial panel in Ottawa and at the Overseas Nurses' dinner on the evening of the unveiling. Wreaths were placed before the panel and on the cenotaph on Armistice Day. The treasurer, Miss Enright, reported a satisfactory year financially, which showed that though the membership is more or less a floating one, there were eighty-eight members for 1926, seven of whom were new members. Mrs. Stewart Ramsay, as convener of the Sick Visiting Committee, reported that the committee was fortunately not called upon many times during the past year, but the hope was expressed that those unfortunate enough to be ill would feel the good-will and sympathy of the association through the committee's efforts. Ten visits were made and flowers sent to each of the sick sisters.

After reports had been given the election of officers for the year 1927 took place, the following being elected unanimously: President, Mrs. Stewart Ramsay (E. Pelletier); vice-president, Miss G. Holland; secretary, Mrs. F. C. Scrimger (Ellen Carpenter); treasurer, Miss Eleanor Handcock; convener, Sick Visiting Committee, Miss Marjorie Ross; convener, Last Post Fund, Mrs. Norman Stewart (C. Stewart); Executive Committee—Mrs. Petch (M. Little); Mrs. H. Routh (L. Achison); Misses Pyke, Raynor, Enright, M. Ross. With a vote of thanks to the retiring president and officers the meeting adjourned.

About seventy members of the Montreal Overseas Nurses' Club spent a very enjoyable evening on January 30th at the Montreal General Hospital Nurses' Residence, playing bridge. There were sixteen tables and six prizes were given. The guests were received by Miss Young, superintendent of the hospital, and Miss Watling, the retired president of the association. A "sit-down" supper was served. The thanks of the association are due to Miss Young for so kindly permitting this gathering to take place in the Nurses' Residence, and to the members who are on the staff of the Montreal General Hospital, whose efforts made the evening such a pleasant one.

A VISITOR FROM CHINA

Miss Cora Simpson, secretary, the Nurses Association of China, who is spending some time in the United States, attended the annual meeting of the Registered Nurses Association of the Province of Quebec, and later spent several days in Toronto. Miss Simpson addressed large gatherings in Montreal and Toronto and was the honour guest at several social functions.

AMALGAMATED

Recently it was announced in England that a Royal Warrant had provided for the amalgamation of Queen Alexandra's Imperial Military Nursing Service and Queen Alexandra's Military Families Nursing Service. The combined nursing service will be designated Queen Alexandra's Imperial Military Nursing Service, and its members will wear the same uniform and badge which at present exists for the Q.A.I.M.N.S.

Helsingfors, Jan. 3rd, 1927.

Miss Flora Madeline Shaw,
President, Canadian Nurses Association,
511 Boyd Building,
Winnipeg, Man.

Dear Miss Shaw:—

I have a kind letter, received some time ago, to thank you for and also to express to you my very best wishes on the occasion of your election. As we are now just starting a new year, let me, at the same time wish you all happiness during 1927. Will you also convey my well-wishes to the association and my thanks for the History of the Canadian Nurses Association, which I am very happy to have got. I was particularly pleased to recognize on the first page my old friend from a long ago congress in Paris, Miss Snively, whom I was happy to meet again some time later in London. I'll never forget, and I do not think any one present on this occasion will ever forget her speech on that memorable occasion. It gave one, and for me this was the first time it happened, such a vivid impression of the greatness, the vastness of the country which is yours. Since then I have met many Canadians and always felt attracted by their spirit, in which there is, to my mind, something akin to ours in Finland.

So I hope you'll feel that it is with my whole heart that I am wishing you all a happy and prosperous new year.

Yours very sincerely,

(Sgd.) SOPHIE MANNERHEIM.

BIRTHS

APPLEBY—Recently, at Vancouver, to Dr. and Mrs. Appleby (Peggy Lawlor, 1919), a son.

CANNING—On November 24th, 1926, to Mr. and Mrs. M. L. Canning (Isobel Walker, Oshawa General Hospital), a daughter (Joan Isobel).

DeMERCHANT—On December 4th, 1926, at Providence, R.I., to Mr. and Mrs. Oscar DeMerchant (Ethel Kee, General Public Hospital, St. John, 1919), a daughter (Joyce Alice).

GILLON—In November, 1926, at Hamilton, to Mr. and Mrs. Frank Gillon (Marjorie Taylor, Kingston General Hospital), a daughter.

HALLETT—On February 3rd, at Toronto, to Mr. and Mrs. Edwin J. Hallett (Grace Kuhring, Royal Victoria Hospital, 1923), a daughter.

HARE—On November 18th, 1926, to Mr. and Mrs. C. E. Hare, a daughter (Doris Elizabeth).

HATCH—Recently, at Vancouver, to Mr. and Mrs. Hatch (Esther Brown, Vancouver General Hospital, 1909), a son.

MacNEILY—On January 2nd, 1927, at Montreal, to Mr. and Mrs. William H. MacNeily (Marjorie Eaton, Montreal General Hospital, 1918), of 2037 Hutchison St., Montreal, a son (Jack Eaton).

MATHEWSON—In December, 1926, to Mr. and Mrs. J. H. Mathewson (Elizabeth White, Western Hospital, Montreal), a daughter.

MELLVILLE — In November, 1926, at Windsor, to Mr. and Mrs. Mellville (Pearl deMille, Orillia Soldiers' Memorial Hospital, 1923), a daughter (Margaret Joan).

SKITCH—On January 13th, 1927, to Mr. and Mrs. Gordon Skitch (Frances M. Railton, Hamilton General Hospital, 1922), a son (Gordon Railton).

WARNER—On February 2nd, 1927, at Kingston, to Mr. and Mrs. George Warner (Myrtle Watts, Kingston General Hospital), a son.

MARRIAGES

ABERNETHY—BECK—On October 27th, 1926, Lillian Beckett (Oshawa General Hospital) to Norman Abernethy, of East Orange, N.J.

ANDREWS—DAVEY—On January 17th, 1927, at Fort William, Rheta Graham Davey, of Owen Sound, to John Andrews, of Fort William.

BARROW — SHAW — On January 29th, 1927, at Montreal, Mary Shaw (Montreal General Hospital), to Septimus Barrow, of Quebec.

BATSTONE — PARRY — On September 17th, 1926, at the China Inland Mission, Chungking, China, Constance Margaret Parry (Toronto General Hospital, 1923), to Mr. William Howard Batstone. Mr. and Mrs. Batstone are living at the China Inland Mission, Chungking, Szechuen, China.

BROWN—NOBLE—Recently, at Sarnia, E. Noble (Sarnia General Hospital, 1919)), to Gordon Brown, of Brigden, Ont.

K. Lamb (Vancouver General Hospital, 1923), to John Clark. At home, Vancouver.

COLE—DOUGLES—In June, 1926, at Port Huron, Mildred Douglas (Sarnia General Hospital, 1925), to William Cole, of Sarnia, Ont.

CROFT — SMITH — On September 15th, 1926, Frances Smith (Oshawa General Hospital), of Port Hope, to R. Croft, of Hampton, Ont.

FABRO — LAMB — On November 18th, 1926, S. Lamb (Holy Cross Hospital, Calgary), to B. Fabro.

HARKER — GRIERSON — On January 15th, 1927, at Wilmington, Ina Grierson (Vancouver General Hospital, 1924), to H. M. Harker. At home, 1052 Broadway, E., Long Beach, Calif.

KENNY — LAST — On November 17th, 1926, Myrtle Last (Kitchener and Waterloo Hospital, 1923), to LeRoy Kenny, of Cleveland, Ohio.

KITELEY—MARSHALL—On September 29th, 1926, at Stratford, Ont., Annie Marshall (Toronto General Hospital, 1920), to the Rev. W. M. Kiteley, of West Lorne, Ont.

LECKIE — FLETCHER — In September, 1926, at Sarnia, Lena Fletcher (Sarnia General Hospital, 1922), to Lawrence Leckie, of Sarnia, Ont.

MILNER—GRAY — On December 20th, 1926, Ouida W. Gray (Orillia General Hospital, 1922), to Cameron Milner, Port Carling, Ont.

MURRAY—McARTHUR — In December, 1926, Gladys McArthur (Victoria General Hospital, Fredericton, 1922), to James Murray, of New Glasgow, N.S. Mr. and Mrs. Murray will reside in New Glasgow.

SANDOWN—SMITH—On January 28th, 1927, Beatrice Smith (Victoria Hospital, London, 1920), to Ninian J. Sandown. Mr. and Mrs. Sandown are residing on the River Road, near Springbank.

SCOTLAND—MOLANDER—On January 15th, 1927, at Calgary, Annie Molander, to Alexander Scotland. Mr. and Mrs. Scotland will reside in Calgary.

SHEPHERD — TURNER — In December, 1926, at Sarnia, Sarah Turner (Sarnia General Hospital, 1921), to Fred. Shepherd, of Sarnia, Ont.

SPARKES—HEATHORNE—On January 12th, 1927, at Vancouver, Priscilla Heathorne (Vancouver General Hospital, 1923), to Wilbur Sparkes. At home, Sacramento, Calif.

STEWART—SMITH—On January 20th, 1927, at Sudbury, Ont., Marion Gertrude Smith (Montreal General Hospital, 1925), of Sudbury, to Kelvin Alexander Stewart, B.Sc.F., of Toronto.

TACKABERRY — MYLES — On January 26th, 1927, Sarah Naomi Myles (Owen Sound General and Marine Hospital, 1919), to William John Tackaberry, L.D.S., Owen Sound, Ont.

WESTON—BAILEY—In November, 1926, at Detroit, Myrtle Bailey (Sarnia General Hospital, 1922), to Charles Weston, of Detroit, Mich.

DEATHS

CLEARY—On Jaunary 10th, 1927, at Almonte, Ont., Annie Hughes (Western Hospital, Montreal), wife of Rufus J. Cleary, late of Willow Farm, Shawbridge, P.Q.

CLELAND—On January 12th, 1927, Annie Russell (Western Hospital, Montreal), daughter of Mrs. Mary A. and the late James Cleland, at the residence of her mother, in Montreal.

HOARE—On January 23rd, 1927, at Pincher Creek, Alta., Maude M. Hoare (Maude Edgard, Royal Victoria Hospital, Montreal, 1907), wife of Thomas Hoare.

BRYDGES—On December 16th, 1926, at New Glasgow, N.S., Nellie Brydges (Moncton Hospital, Moncton, N.B., 1922).

McKILLOP—January 10th, 1927, at Parkhill, Ont., Christine McKillop (Sarnia General Hospital).

Canadian Red Cross Has Spent Six Millions Since the War on its Peace-Time Programme

That in round figures the Canadian Red Cross Society has disbursed since the war six millions ($6,000,000) of dollars in furthering its national peace-time programme; that about one-half the revenues of this society, available at the end of the war with the revenues accruing since, has been spent for the benefit of disabled members of the Canadian Forces; that the other half has gone largely into the public health and health education activities of the organization; and that last year the sum of six hundred and fifty thousand dollars ($650,000) was spent on Red Cross work in all parts of Canada, will be the gist of a statement to be issued at an early date from Red Cross Headquarters in Toronto.

This statement, which has been prepared by Dr. James W. Robertson, Chairman of the Central Council of the Red Cross in Canada, and Lieut.-Colonel J. L. Biggar, M.B., Chief Commissioner, will deal in detail with the causes which made it imperative at the close of the war that Red Cross work should go on without pause; will outline the peace-time constitution of the world League of Red Cross Societies and of the Canadian Red Cross; will show that Red Cross health education as furthered by the Red Cross and other health agencies in Canada has been largely responsible for the fact that since the war many thousands of Canadian school children have been medically examined; will refer to the fact that the Junior Red Cross, which originated in Canada in 1914, has now over 100,000 members in the Dominion and has spread into many other lands where it today numbers ten millions; will state that in the past three years 11,000 women have taken the Red Cross Home Nursing courses, will announce that 5,873,745 pieces of health literature have been distributed by the Red Cross; will describe the invaluable services afforded settlers in the hinterlands of the Dominion through the thirty-nine Red Cross Outpost Hospitals now in operation in many provinces; will make known the very definite contributions made to safe and satisfactory settlement of immigrants through the Seaport Nurseries of the Red Cross and the follow-up records kept in these unique institutions; will enter into details regarding what has been done by way of disaster relief in the past seven years and will outline the tasks for the future if all such urgently necessary work is to be carried forward.

It is understood that this statement will precede a nation-wide campaign for national support of the Red Cross and that this campaign will be launched on Empire Day in all parts of the Dominion and will continue until Dominion Day, 1927.

An Etching of the Memorial Panel

An etching of the Memorial has been drawn by Mr. S. H. Maw, of Montreal, and an edition of 125 numbered and signed pulls has been issued. Of these copies, fifty were disposed of by the Memorial Committee, and Mr. Maw has now seventy-five etchings for sale. The price is $20.00 each with a discount of 40% for nurses, making the net price for each etching $12.00. Miss Jean Wilson, Executive Secretary of the Canadian Nurses Association, 511 Boyd Building, Winnipeg, will take orders for the etchings, and these orders will be filled in the order of their arrival as long as the etchings last. No order can be accepted unless the money accompanies it. If paying by cheque, please make sure that fifteen cents is added to your cheque to pay exchange. Make cheques payable to Miss Katharine Davidson (as Miss Davidson is Treasurer of the Memorial Fund). Anyone wishing to do so may order direct from Mr. S. H. Maw, 216 Percival Ave., Montreal.

On behalf of the Memorial Committee,

E. K. RUSSELL,

Secretary.

Editor's Note—The article on Midwifery in England, by Miss Mary Beard, the first instalment of which appeared in the February number, was given as an address by Miss Beard before the Public Health Section, Canadian Nurses Association, August, 1926. Miss Anne Slattery's article on Midwifery Legislation in Canada was read before the same section. Miss Beard's article was published in The Public Health Nurse in December, 1926, and January, 1927.

New Brunswick nurses and especially New Brunswick school nurses will be interested to learn that the order for the January number of The Canadian Red Cross Junior for New Brunswick was 4,500, the largest number yet taken by any province. The total number for January for the whole of Canada was 18,059.

The Canadian Nurses Association offers its congratulations to the Juniors and to the Editor of the Canadian Red Cross Junior, Miss Jean Browne, retired President, C.N.A., for the growth of the Junior organization and for their excellent monthly magazine, which, in January, 1927, entered its sixth year of publication.

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HELEN RANDAL, R.N., Registrar
125 Vancouver Block - Vancouver, B.C.

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Dear Editor:—

Am sorry my renewal is a little late. I have been a subscriber to The Canadian Nurse for twenty years and just could not do without it. I am always glad to recommend it and give my copy to the younger nurses as they start out. Wishing you all success.—A.B.C.

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Editor and Business Manager: JEAN S. WILSON, Reg.N.

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CONTENTS

		PAGE
Local Anaesthesia	*Dr. W. Easson Brown*	171
Editorial		174
The New Home and Teaching Unit, The Montreal General Hospital School for Nurses	*Frances Reed*	177
Enemas	*M. Louisa Parker*	180
The Nurses Association of China	*Hope Bell*	182
Review of an Address on Diabetes	*Dr. Banting*	184
Review of Paper on Diabetic Coma	*Dr. Gladys Boyd*	185
With the League of Red Cross Societies		186
Health Superstitions	*Dr. J. J. Heagerty*	187
Department of Nursing Education: Instructors' Problems: Round Table (Cont'd)		191
Department of Private Duty Nursing: The Nurses' Registry		196
Department of Public Health Nursing: The Scenic Health Poster	*Anna E. Wells*	199
A Course in Public Health Nursing	*Olive Watherston*	201
Book Review		198
News Notes		204
Official Directory		213